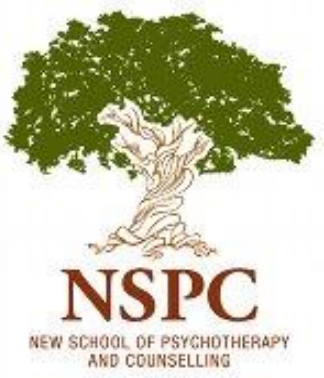

Exploring Learning Outcomes in CBT and Existential Therapy in Denmark

Submitted to Middlesex University and the New School of Psychotherapy and Counselling in partial fulfilment of the degree Doctorate (DProf) in Psychotherapy and Counselling.

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March 2015

Content

Acknowledgements

Jonathan Turner performed professional proof reading.

I owe a deep gratitude to my supervisors, Dr. Rosemary Lodge and Dr. Emmy van Deurzen, who helped me through this research project.

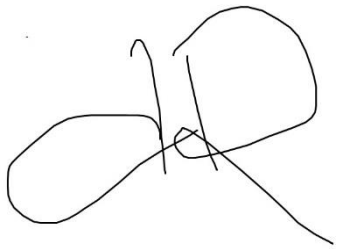
I owe a sincere gratitude to my mother, Margit, without whom my research project would not have been possible. I dedicate this thesis to her.

Finally, I would like to say thank you to my examiners, Dr. Simon du Plock and Dr. Pavlos Filippopoulis for their time and valuable comments.

Statement of Copyright and Originality

This is an original research project.

The Ethics Committee at the New School of Psychotherapy and Counselling provided ethical approval for this work.



Anders Dræby Sørensen, 2015.

Word count including spaces

58.968 words (79.745)

Abstract

The purpose of this thesis is to draw attention to the special characteristics of the outcome of psychotherapy through qualitative research. The thesis explores a phenomenological and hermeneutic enquiry into the lived experience of psychotherapy in terms of learning outcomes. This includes both Existential therapy (ET) and Cognitive-behavioural therapy (CBT) and their possible differences and similarities. I can describe learning as any experiential change that occurs in the participants understanding as result of the therapy in which they participate. Learning outcomes are concerned with the achievements of the learner rather than the intentions of the educator, as expressed in the objectives of an educational effort.

The thesis uses Interpretive Phenomenological Analysis (IPA) as a qualitative method to explore meanings of the learning phenomenon generated from themes found in transcripts of semi-structured interviews from twelve participants with an equal length of short time client experience of psychotherapy. That is, six participants who had attended CBT and six participants who had attended ET.

Consistent themes from the data indicate that, overall, psychotherapy helps clients to enhance general learning in three major domains: (1) Self and life; (2) Thinking, acting and feeling; (3) Relationships with others. The data also indicates that ET overall helps clients to enhance particular learning of authenticity and insight into self, life and relationships with others with courage, engagement and freedom in an open and personal approach to difficulties and life issues. Furthermore, the data indicates that CBT overall helps the client to enhance particular learning of self-capability and self-esteem with independence in self-chosen relationships and capabilities for

organized and appropriate approach to difficulties and life issues. Thus, ET is more oriented towards learning authenticity and self-positioning in life, whereas CBT is more oriented towards learning capabilities for organized and appropriate ways of thinking, acting and feeling.

This research points to the value of the learning perspective for therapeutic practice and facilitates a model of psychotherapeutic learning with an understanding of learning outcomes based on motivational learning, learning to do with previous experiences, learning design for process, the therapeutic learning relationship and the educational role of the psychotherapist.

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Chapter 1. Introduction

1.1. Aim of the research

The project is based on the current need for a nuanced and comprehensive understanding of the outcome of psychotherapy, as part of an evaluation of the conceptual and empirical foundations of different therapeutic approaches. The literature review suggests that it is possible to widen such understanding by focusing on psychotherapy as a general term for various related types of *learning methods* that have different *educational objectives*. These differences might result in different *learning outcomes*, which I will investigate in terms of the clients lived experience of psychotherapy. I do this in order to provide a nuanced understanding that does not assess the outcome of psychotherapy using measures and rating-scales. The learning outcome is the actual achievement of the learner. My project focuses on the lived experience of the learning outcome of two psychotherapeutic approaches; Existential therapy (ET) and Cognitive-Behaviour therapy (CBT). The objective is:

1. To explore the significance of the motivation for the choice of therapy for the understanding of the lived experience of the learning outcome in CBT and existential therapy
2. To explore the understanding of the lived experience of the outcome in CBT and existential therapy in Denmark and the ways in which it involves an enhancement of learning.
3. To explore the differences and similarities in the understanding of the lived experience of the learning outcome of existential therapy and CBT.

1.2. Relevance of Research to the Field of Psychotherapy

This study argues that learning is a relevant criterion for evaluating psychotherapy. Learning is the experiential process of changing ones understanding. Learning might be explicit or implicit. The concept of learning covers all psychological changes that involve an alteration in a person's understanding and experience of the world. Therefore, learning is especially useful for a qualitative evaluation of change, in psychotherapy that focuses on changes in the way in which people understand and experience their world.

This study addresses the learning outcome of ET and CBT in terms of what participants have learned from psychotherapy. Through qualitative research methods, my study focuses on the lived experience of this outcome. It also focus on how the lived experience of the learning outcome of CBT and ET might differentiate.

This study is important to the development of psychotherapy in terms of practice and theory, given general discussions of the evaluation of the empirical and conceptual foundations of psychotherapy. Even though it has been customary to conceptualize the developmental changes of modification that take place in a client during psychotherapy as forms of learning processes, almost no one has actually accepted the full implications of this perspective and conceptualized outcome research within this framework. IPA gives the opportunity of qualitatively assessing in-depth psychotherapy outcomes that reliably reflect the therapeutic learning that impact clients and the changes that are unique and special to individual clients. Thus, the ambition of this study is to assess what clients actually learn from psychotherapy with the potential of providing the basis for a new framework for assessing psychotherapy. Learning outcomes in terms of the achievements of the learners might serve as an alternative to quantitative assessments of psychotherapy as a medical treatment

technology using diagnostic measures and rating scales. It is very important to know how the clients actually experienced the learning outcome of psychotherapy and whether the outcome was different in cognitive-behavioral therapy as opposed to existential therapy. There are also implications of this research for the training and development of therapists.

1.3. Personal motivation for research

Apart from my DProf studies, my educational background is a Master's degree in the History of Ideas and Philosophy of Medicine, a Master's degree in Humanities and health studies, a BA degree in the History of Ideas, a BA-Minor in General psychology and a MA-Minor in Applied psychology. My combination of philosophy and psychology was one of the main reasons why I decided to do a doctorate in existential psychotherapy and counselling. As part of my DProf studies, I have been in personal existential therapy. Previously, I have also had client experience in psychoanalysis and CBT.

My inspiration for this study came from my previous professional background as a teaching associate professor and head of counselling at the Danish School of Education. At the time I began working on my doctorate proposal, part of my work consisted in trying to develop an educational approach to counselling and psychotherapy that was based on learning theories. Therefore, I became interested in investigating, whether it would be possible to evaluate existing approaches to psychotherapy in learning terms rather than clinical terms. From an educational perspective, the clinical approach to evaluating psychotherapy seemed too narrow and did not make proper sense from my position. Thus, my interest in the learning dimension made me wonder, if it would make more sense to evaluate psychotherapy in terms of learning and what perspective that might provide for understanding the conceptual and empirical basis of psychotherapy.

After submitting my proposal, I stopped working at the Danish School of Education. This life change provided me the opportunity for a completely free and open-minded attitude to my research project. Thus, I have been able to approach my research project from a position of pure curiosity. Consequently, I have been very open to the surprises that this research project gave me. I did not base my research project on any prerequisite theories or hypothesis, and I have been genuinely surprised about the results of my research. In general, I was very surprised about the huge similarity of the findings between CBT and existential therapy (ET). Perhaps, the theory somehow suggested the difference between ET and CBT to be much bigger. However, I was not looking for anything special and actually, I was also very surprised about the kind of differences between ET and CBT. These differences showed that even though ET and CBT tend to be very similar, there is also a substantial difference between the lived experiences of the two approaches. I was particularly surprised about the big difference in the learning design and educational role of the therapist. Furthermore, every transcript represented a surprise to me. I was stunned by the details and nuances that the participants articulated and it made me realize that the lived experience of psychotherapy is a very deep and complex experience.

1.4. Schedule of changes

This is a resubmission of the thesis according to the specifications supplied by the examiners. In this section, I refer to the schedule of changes indicating where these have been made in the text.

1. I have expanded the reflexivity section in section 6.4.2 on influences from the researcher, including reflections on researcher as self, therapist and researcher.

2. I have improved section 1. 1. on aim of the research. I have added section 2.7 joining research objectives and research questions. I have also added a research schedule in Appendix 0A and a timetable in Appendix OB. Finally, I have expanded on the presentation of the interview guide in section 3.7.
3. I have removed judgmental descriptions on participants in section 3.7 on data collection.
4. I have expanded section 3.1 on choice of methodology, including stronger rationale for choice of IPA.
5. I have revised statement on lack of previous' in section 6.5.4 and included in my literature review, a consideration of the work based on Miles Cox and Jutta Heckhausen.
6. I have expanded the section on ethics to include a whole chapter, adding subsection 4.4 on precautions by proofreading.
7. I have changed the title to *Exploration of Learning Outcomes in CBT and Existential Therapy in Denmark*.

Chapter 2. Review of literature

From the literature review, I have developed five lines of investigation that are the basis for my research:

2.1. Today, dominant trends in the evaluation of psychotherapy connect to different types of evidence-based assessments by clinical health technologies. These trends are associated with efforts to conceptualize the results of psychotherapy in terms of clinical outcome and trends to measure and compare the relative efficacy and effectiveness of the different therapeutic orientations.

2.2. It is possible to evaluate psychotherapy as an educational method in terms of educational objectives aimed at learning outcomes, which leads to a more nuanced and comprehensive understanding of the empirical and conceptual foundations of psychotherapy.

2.3. The educational objective of CBT is that clients unlearn maladaptive pathological skills, strategies and patterns of thinking, feeling and behaving and learn more healthy and adaptive cognitive and behavioural skills.

2.4. The educational objective of existential therapy (ET) is that clients undergo an existential transformation and learn capabilities to be authentic, to be aware of their actual existence and to live with engagement, freedom and courage in accordance with their own values, beliefs and experiences.

2.5. There are theoretical differences and similarities between CBT and ET as learning based therapeutic designs for enhancing educational objectives of certain learning outcomes.

My definitions of the educational objectives of CBT and ET are the results of the third and fourth section of the literature review. These definitions will function as part of the theoretical framework for my discussion of the lived experience of the learning outcome of CBT and ET.

2.1. Dominant trends in the evaluation of psychotherapy

2.1.1. The relevance of evaluating the conceptual and empirical foundations of psychotherapy

For decades, there have been discussions about and efforts toward the evaluation of the conceptual and empirical foundations of psychotherapy. These have involved institutional and political debates, theoretical and philosophical discussions as well as outcome research on the effect of

psychotherapy, and process research into the elements in effective psychotherapy (Cummings 2000; Roth 2006; Cooper 2008; Wampold 2009; Norcross 2011).

Psychotherapy rests on the basic assumption that a human being is changeable through psychological procedures. Thus, fundamental questions in relation to the subject of psychotherapy are what the essential nature of psychotherapy is, and whether there is anything specific and characteristic in the process and outcome of changing a human being through psychotherapeutic intervention. These factors are important because they clarify the basis, orientation and intention as well as the implications of psychotherapy. They also affect the questions of whether psychotherapy is a worthwhile endeavor at all, whether psychotherapy will work or not, which particular approach to psychotherapy might be the right choice for a particular person or problem and how clients experience the process and outcome of psychotherapy (see Barker 2010, Ch. 13).

2.1.2. Clinical guidelines and evidence-based assessments

In Britain and Denmark evidence-based assessments of various kinds of psychotherapy have been used for the development of *clinical guidelines* for the treatment and management of so-called mental and behavioural disorders or diseases (e.g. NICE 2006; Sundhedsstyrelsen 2012). Such guidelines are used to inform choices of a therapeutic approach and they presume that psychotherapy is best conceptualized as a medical treatment.

2.1.3. The medical model

Thus, most of these clinical guidelines are based on a *medical model,* which assumes that psychotherapy is primarily a clinical technology (Wampold 2009, Ch. 1). That is, a technology that

contributes to the treatment and management of mental disorders and health. This assumption closely links to the idea that the primary objective of psychotherapeutic intervention is to relieve or remove the symptoms of psychological distress and inadequate reactions according to diagnostic criteria or other clinical measurements. Therefore, the medical model tends to evaluate psychotherapy in clinical terms. This also means that it is possible to compare and mutually measure the different approaches to psychotherapeutic intervention with reference to clinical diagnosis-measures and rating scales. This is the main rationale behind the clinical guidelines, which have great importance for current and future evaluation and development of psychotherapy.

2.1.4. The outcome of psychotherapy

Main questions in these and other ongoing discussions and efforts to evaluate psychotherapy are: What is the change that psychotherapy can bring about, and how do researchers study and report the result of therapeutic change? These are questions about the outcome of psychotherapy. The issue of outcome has great importance in the assessment and evaluation of different approaches to psychotherapy.

According to Cooper, most outcome research has focused on the assessment of the general *efficacy* of counselling and psychotherapy (Cooper 2008, 16). Thus, according to Cooper, outcome studies tend to focus on *whether* psychological therapies produce an *effect* in relation to certain psychological problems. Typically, the efficiency of psychotherapy in relation to such states of psychological distress is measured in positive changes of behaviour or other external characteristics and conceptualized in terms of *clinical outcome*. Other efficacy studies focus more specifically on the *effect size*, i.e. how much positive effect psychotherapy has. Alternatively, they focus more specifically on the *clinical change*, which is often defined by diagnostic criteria, i.e. how many people

in psychotherapy achieve their desired clinical outcome in relation to states of psychological distress (Cooper 2008, 16).

We have already noticed how it is currently becoming increasingly prevalent to mutually rate and compare the outcomes of different approaches. Typically, this points to the question of the *relative efficacy* and *effectiveness* of different therapeutic orientations. Clinical guidelines are part of a growing trend to detect or argue that some approaches to psychotherapy are more efficacious for certain forms of psychological distress than others (Cooper 2008, 37). As we have seen, the UK's National Institute of Health and Clinical Excellence and Denmark's Sundhedsstyrelsen adopt such an approach in determining which psychological therapies to recommend for the treatment of particular forms of psychological distress.

2.1.5. Challenges

This project is based on questioning the assumptions behind the four connected ideas of: (i) evidence based assessment; (ii) the medical model; (iii) conceptualization of change in terms of clinical outcome; (iv) the differential effectiveness position. It also questions the implications of these ideas for the evaluation of the empirical and conceptual foundations of psychotherapy.

The current trend of appreciating and funding evidence-based practice hinders a more comprehensive understanding of the conceptual and empirical foundations and implications of psychotherapy. It especially hinders a more nuanced conception and evaluation of the outcome of psychotherapy. The instrumental focus on clinical outcome does not take into account how clients experience the outcomes of different types of psychotherapy in a broader sense. Furthermore, the medical model does not take into account that psychotherapy may be understood as a rich tapestry

of intersecting therapeutic practices. There are over 250 distinct psychotherapeutic approaches, which may be characterized by family-similarities and common factors. However, the different approaches also include different forms of practice and orient themselves around different concerns, aims and types of objectives. The differential effectiveness position does not take into account that this diversity may result in different ways in which the client experiences the outcome of psychotherapy.

2.2. Evaluation of psychotherapy in terms of learning

It is possible to shed new light on the problem concerning the understanding and evaluation of psychotherapy by incorporating knowledge of the continuity of psychotherapy with psychological processes other than healing processes, like educational or learning processes.

2.2.1. Learning outcomes and educational objectives

While medicine and health technologies typically define their aim and objective as a unique and measurable clinical outcome, in education it is common to operate with various types of *learning outcomes* reflecting different types of educational and pedagogical interventions. These outcomes relate to different types of *educational objectives*. Learning outcomes are specifications of what a learner should learn as the result of a specified and supported learning program. They can take many forms and be broad or narrow in nature. Furthermore, they are concerned with the achievements of the learner rather than the intentions of the teacher or educator, as expressed in the objectives of an educational effort (Moon 2002; Adam 2004).

I will use this insight into learning outcomes and educational objectives in relation to psychotherapy, because it is customary to conceptualize the developmental changes that take place in a client during psychotherapy as forms of learning. This is in spite of the fact that almost no one has actually accepted the full implications of this perspective.

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2.2.2. The tradition of integrating psychotherapy and learning theory

The conceptualizations and evaluations of psychotherapy in terms of learning have been especially prevalent since the 1950s. They have primarily consisted of attempts to integrate theories of psychotherapy and theories of learning and education: (1) To understand and interpret the dynamics of psychotherapy in the light of a learning-theory framework or vice versa (French 1933; Dollard 1950; Alexander 1963; Brady 1967; Greenbaum 1979; Greenbaum 1985; Youell 2006; Smail 1980). (2) To understand psychotherapy as an educational practice (Salmon 2011; Petek 1991; Fuhr 1988). (3) To actually integrate learning principles into systematic psychotherapeutic application, for example in behaviour therapy (Eysenck 1959; Bandura 1964; Bandura 1967; Jones 1924; Shaw 1961; Yates 1958; Milne 1984; Catell 1987; Porter 1968), conditioned reflex therapy (Salter 1949), psychodynamic therapy (Stampel 1967); psychodynamic and behaviour therapy (Murray 1963); cognitive therapy (Mahoney 1977; Dowd 1996; Strupp 1988) or person-centred therapy (Rogers 1967).

It is important to notice that the concepts of education and learning function in different ways and have different purposes within these different approaches. My specific aim is to investigate whether and how the concepts of learning outcome and educational objectives make sense for the conceptualization and evaluation of psychotherapy.

2.2.3. The relevance of evaluating psychotherapy from a learning perspective

From the 1950s onwards, psychotherapeutic approaches have been increasingly evaluated in terms of clinical effectiveness regarding the healing of mental conditions. Thus, in 1952 Eysenck started a tradition of evaluating psychotherapy in light of research into the outcomes of psychotherapeutic intervention, with reference to a unit or criterion of measurement of the effectiveness regarding removal of pathological symptoms (Eysenck 1952; Weisz 1995; Compton 2004). The existing tradition of viewing psychotherapy in learning terms, however, raises the possibility of an entirely different type of evaluation of psychotherapy (Sørensen 2012). This is not about assessing clinical effectiveness or judging the pragmatic truth, but about facilitating a more nuanced understanding and comprehensive evaluation of the different types of learning outcomes implied in different approaches to psychotherapy. At the same time, learning represents a more complex and multifaceted psychological process than healing. This reflects in the rich diversity of learning theories about different kinds of human development as well as in the variety of educational and pedagogical theories on upbringing, education, didactics and training as media for facilitating developmental learning (Santrock 2008). Learning is a broad phenomenon that has many aspects and is affected by many parameters and there is no theory of learning that is widely accepted. This complex diversity opens a new horizon for the evaluation of psychotherapy. Moreover, some researchers have pointed out that healing processes that occur in psychotherapy might simultaneously be understood in terms of learning processes (Smail 1980). Therefore, a learning perspective does not appear to rule out medical approaches to psychotherapy. Rather it has the ability to include them in a broader understanding, encompassing the perspectives of psychotherapy as a form of healing/treatment or as a form of personal development (Smail 1980).

As early as 1966, Kiesler pointed out several problems with the so-called 'uniformity myth' suggesting that both process and outcome are different between different clients, therapists and approaches to psychotherapy. The learning outcome approach to the evaluation of psychotherapy directly accepts the consequences of Kiesler's perspective (Kiesler 1966).

The purpose of such evaluation is not to produce a normative ranking or comparison of the outcome of different approaches to psychotherapy, which may have completely different aims. Rather, qualitative research lends itself to in-depth study of the learning outcome of psychotherapy experienced in terms of actual achievements of the learner rather than the intentions of the psychotherapist or educator. The intention is expressed in the objectives of the therapeutic approach. In order to gain a nuanced and comprehensive picture of psychotherapy in terms of experienced learning outcome, it will be useful to combine differing forms of learning outcome from different approaches to psychotherapy. From a descriptive perspective, it will also be instructive to explore whether there appears to be qualitative similarities or differences between them. Because this type of evaluation does not incorporate outcome measures and criteria of clinical effectiveness, the purpose of the comparison will not be to establish mutual rating or judgment.

Most outcome research has not been conceptualized within this framework. However, recently there have been a few efforts towards developing methods for assessing outcomes in terms of learning that reflect changes specific to individual clients (Clare 2004). Thus, McLeod describes an interesting trend in the conceptualization of psychotherapy in terms of learning (McLeod 2011, 258). He points to a recent theme that has emerged from qualitative research into the process and outcome of psychotherapy as the registration that clients report how learning constitutes an essential part of their experienced process or outcome (e.g. Morris 2005; Clarke 2004; Perren 2009).

When researchers ask clients how they experienced therapy, they tend to articulate their experience in terms of what they have learned in order to tackle their problems and change their lives.

Burnett conducted a qualitative content analysis, indicating that participants' written responses to counselling were best categorized in terms of three broad areas of learning: Self, Relationships with Others, and the Process of Learning and Change (Burnett 2000). Burnett also conducted studies on how to use learning journals in counselling strategy and how to use solo taxonomy for assessing participants written responses to counselling (Burnett 1999; 2002). However, Burnett made these studies without reference to counselling approaches.

A study by Glasman, Finley and Brooks demonstrated how former CBT clients tended to engage in self-therapeutic activity by adapting and improvising around what they had learnt in therapy for coping and self-management (Glasman 2004).

A study by Carey and others, suggested that regardless of approach, change in psychotherapy occurred across the three domains of feelings, thoughts and actions, by means of six aspects: motivation and readiness, perceived aspects of self, tools and strategies, learning, interaction with the therapist and the relief of talking (Carey 2007).

However, none of these studies focused directly on the experienced learning outcome from psychotherapy related to specific therapeutic approaches and educational objectives.

Some theories and studies on learning in psychotherapy take relate to the motivational psychology of Cox and Klinger, Heckhausen and Heckhausen (Heckhausen 2010; Cox 2011). Their goal-oriented

approaches relate to the cognitive and partly to the behavioural tradition in psychology. According to Heckhausen and Heckhausen:

> "The psychology of motivation is specifically concerned with activities that reflect the pursuit of a particular goal and, in this function, form a meaningful unit of behaviour" (Heckhausen 2010, 1).

According to Holtforth and Michalak, this involves that motivational processes are important for the change of behaviour and experience that are the purpose of psychotherapy (Holtforth 2012, 441; Grawe 2004). From this perspective, it may be useful to consider motivational issues in psychotherapy for all clients. Thus, the goal of every type of psychotherapy is to increase the motivation in clients in order to reduce their psychopathological conditions. This means that motivation has a direct impact on the outcome of psychotherapy (Holtforth 2012).

The goal-oriented approaches address the motivational processes involved in choosing and pursuing goals as cognitive representations of what a person wants to achieve or avoid in in his or her life (Cox 2011, 3; Holtforth 2012). These approaches consider personal as important for well-being and psychological problems (Holtforth 2012). Psychotherapy may use the clients' goals and other motivational factors, including the construction of therapeutic goals, to facilitate change and foster the therapeutic outcome. Empirical studies show an association between therapeutic goals and therapy outcome (Berking 2005; Willutzki 2004). Grawe discusses the motivational and goal processes in psychotherapy from the perspective of cognitive and behavioural learning theories (Grawe 2004, 2.18). From the perspective of expectancy-value theories, Grawe also shows how we might conceive the learning outcome in psychotherapy in terms of how the expectations as well as values of goals affect the subsequent psychological functioning and behavior (Grawe, 2004, 2.19). Thus, motivational factors are associated with the learning and outcome of psychotherapy.

However, these theories and studies are based on specific theories of learning and motivation. They do not address the question of how clients in a broad sense understand the lived experience of the outcome of different therapeutic approaches.

2.2.4. The relevance of evaluating experienced learning outcome in ET and CBT

In order to achieve a nuanced and comprehensive understanding of the lived experienced outcome of psychotherapy in terms of learning, this study will explore two different types of psychotherapy, both of which show the empirical and conceptual basis for psychotherapeutic practice in terms of learning.

According to several researchers, CBT and the cognitive and behavioural tradition in psychotherapy are based on an explicit integration of psychotherapy and specific learning models (Hougaard 2004; Zeiss 1996; Williams 2008; Mahoney 1977; Dowd 1996; Strupp 1988; Eysenck 1959; Bandura 1964; Bandura 1967; Jones 1924; Shaw 1961; Yates 1958; Milne 1984; Catell 1987; Porter 1968).

According to Cooper, ET includes various existential approaches to therapy using different methods (Cooper 2009). This research project will focus on the British School of Existential Analysis, which involves a special model for what needs to be made sense of and understood in therapy.

It will be necessary to clarify the role which learning is assumed to have within the two different types of psychotherapy.

2.3. The integration of learning models in Cognitive Behaviour Therapy (CBT)

What we term as Cognitive-behavioural therapy (CBT) is an integration of particularly two approaches to personality and the development of psychological difficulties: a behavioural and a cognitive approach. According to Hougaard, it is common within the cognitive and behavioural tradition to perceive therapy as an educational method of learning. In the following, I will trace some of the assertions that appear to underlie a cognitive-behaviour-learning hybrid (Hougaard 2004, 38).

2.3.1. Behaviourism and Behaviour Therapy (BT)

We can partly trace the foundations of cognitive behavioural approaches to psychotherapy to the development of Behaviour therapy (BT). Wolpe, Eysenck and Lazarus popularized behaviour therapy in the 1950s (Fishman 2011). They helped to launch the approach as a direct systematic application of theories and methods from the experimental learning psychology of Pavlov, Watson, Skinner and Hull in the tradition of behaviourism (Rachman 2009, 3). Behaviourism is clearly rooted in the process of learning.

Traditionally, behaviourism focuses on human behaviour as the observable object of psychology. According to Christensen, this focus involves an identification within behaviourism of human behavior as the primary psychological function, which can provide an insight into the human psyche (Christensen 2009: 64). The basic assumption is that it is possible to explain external human behaviour as *learned reactions* to external events, originally without reference to internal mental states. Therefore, learning is defined as the process by which changes occur in an individual's behaviour (Pavlov 1927; Brady 1967; Skinner 1969; Bandura 1969).

BT is based on the assumption that pathological behaviour is the result of such learning mechanisms. Therefore, it is possible to re-conceptualize psychotherapy in behavioural terms as a method directed at unlearning maladaptive pathological behaviour and learning adaptive or so-called normal behaviour. Thus, in the 1950s Wolpe and Lazarus introduced laboratory-derived therapeutic techniques based upon the principles of counter conditioning for the treatment of patients with neurotic disorders (Wolpe 1958; Lazarus 1958). Simultaneously, both Skinner and Eysenck defined BT as the application of modern learning theory to the treatment of mental disorders. By learning theory, they both meant the principles and procedures of behaviourism (Eysenck 1959; Skinner 1953). Contrary to psychoanalytic psychotherapy, this behaviouristic movement involved a reconceptualization of clinical mental health problems as educational learning problems. The primary emphasis was on accepting human behaviour as the critical subject matter and establishing modification to behaviour as a learning oriented treatment approach to psychotherapy (O'Leary 1975). In this perspective, the objective of BT is the unlearning of pathological behaviour and the learning of normal or appropriate behaviour according to diagnostic measures (Corey 2005, 238; Clark 2009, 8).

2.3.2. Cognitive Psychology and Cognitive Therapy (CT)

Cognitive therapy (CT) was developed by several researchers in the 1950s and 1960s and was primarily spread and popularized by Beck as part of the so-called "Cognitive Revolution" in psychology (Hollon 2011; Saugstad 1998: 524-535).

Part of Beck's initial inspiration was the constructivist cognitive psychology of Piaget, according to whom humans go about making sense of the world by gathering and organizing information: information processing. Thus, according to Piaget's theory of learning, our approach to the world is

mediated through cognition. In this sense, learning means that human beings develop cognitive structures through their reactive and proactive adaptation to the world. This development of cognitive structures is achieved by the learning based formation of internal cognitive schemas, which are mental representations that organize cognition as hypothetical constructs (Piaget 1969; Mahoney 1988, 201).

Beck launched CT as a modification of psychoanalytic psychotherapy. It involves a distancing from the focus on uncovering the deeply buried and hidden life-historical motives behind pathological symptoms (Beck 1970). Based on clinical experiments, Beck focused on those "here and now" thoughts that are hardly concealed beneath conscious awareness and Beck conceptualized cognition as available to us knowingly. He based his theory on the assumption that, as human beings, we interact with our environment through the processes of thinking, interpretation and evaluation. In turn, these linked to our feelings and behavior. Thus, Beck developed the theory that an individual's affective states and behaviour are determined by their cognitive way of structuring the world through beliefs and expectations (Beck 1991, 114; Rachman 2009, 13). According to Beck, there are three types of cognition. Firstly, *information processing* describes how individuals constantly receive information from within themselves and their environment. Secondly, Beck suggests that certain experiences actively lead individuals to create cognitive *schemas* in their adaption to life. Schemas are described as hypothetical cognitive structures that act as templates to filter the incoming information and to govern and evaluate behaviour (Mytton 2012, 287). These schemas involve a cognitive triad of beliefs and expectations regarding the self, the environment and the future. Thus, a depressive person forms a depressogenic schema containing dysfunctional assumptions:

> *"His interpretation of his experiences, his explanations for their occurrence, and his outlook for the future, show respectively, themes of personal deficiency, of self-blame and negative expectations. These idiosyncratic themes pervade not only his interpretations of immediate situations but also his free associations, his ruminations, and his reflections" (Beck 1970: 285)*

Thirdly, *automatic thoughts* represent an individual's internal dialogue that occurs in an unplanned way (Beck 1991). Automatic thoughts are derived from the schemas that the individual is not aware of. Thus, maladaptive thinking is often a habit and individuals are only semi-aware of its existence. The dysfunctional assumptions of the depressogenic schema are activated by critical incidents that produce negative automatic thoughts leading in turn to other behavioral, motivational, emotional and physical symptoms of depression, which produce more negative automatic thoughts and thereby form a vicious circle.

Beck accepts conventional psychopathology and diagnostic categorization of mental disorders as phenomena with a particular symptomatology. Thus, the cause of pathological symptoms is that the patient has learned a maladaptive dysfunctional scheme (Beck 1970, 255-6, 282). This involves an acceptance that CT is a hybrid of an educational and a medical or clinical model.

In practice, cognitive therapy is essentially an educational-clinical method based on a corrective learning strategy. The educational aspect involves an identification and unlearning of maladaptive dysfunctional thinking and a learning of adaptive and functional patterns. Thus, the therapist facilitate the client to identify problematic cognitive processes and the therapist supports the client to challenge and re-structure this thinking. Thus, the client is educated to be his/her own therapist. The clinical aspect involves curing of the patient, which consists of getting relief from those

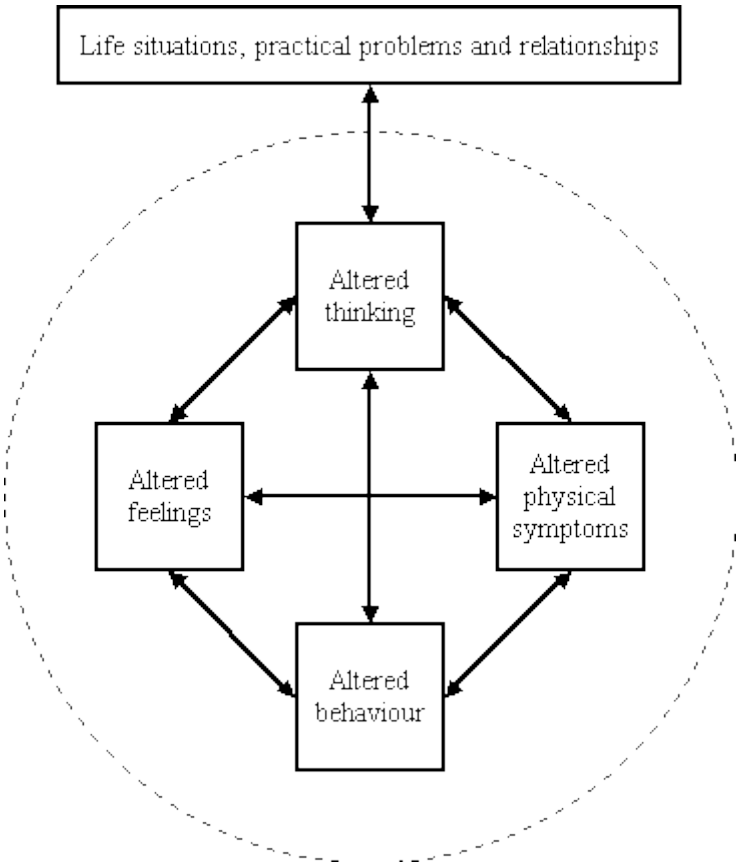
pathological symptoms, which are included in the clinical diagnosis (Beck 1991; Beck 1970, 319-326; Beck 1995, 269; Beck 1970b, 184).

BT is associated with an idea that it is easy to measure the assessment of problems and the outcome of treatment by observing behaviour. This idea has also gained ground in CT, which uses a variety of methods and instruments for measurement in assessment and treatment. Among others, it utilizes the Beck Depression Inventory, which is a self-reporting instrument for measuring the severity of depression composed of items relating to symptoms of depression.

2.3.3. Cognitive-Behaviour Therapy (CBT)

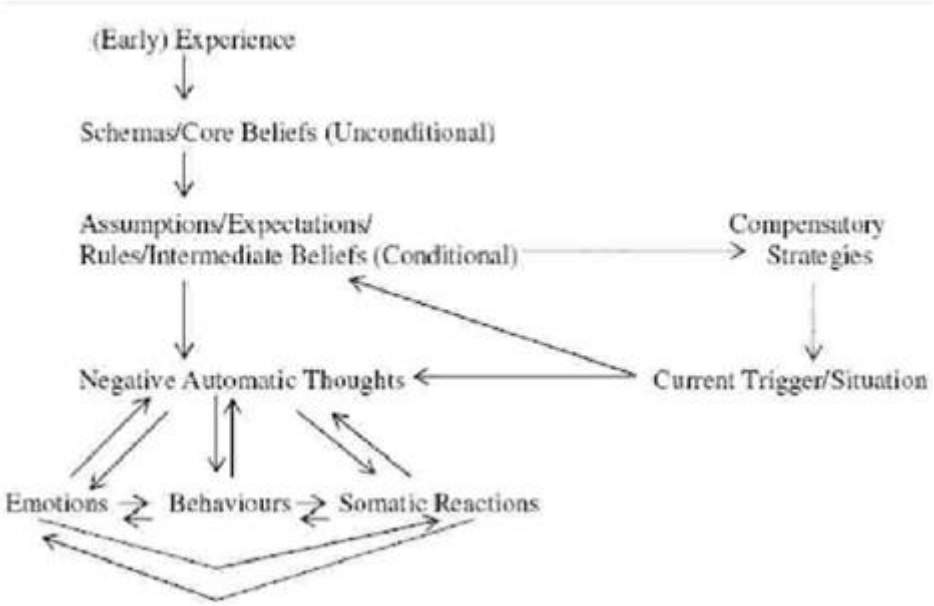
Although BT and CT often articulated as opposites, both approaches are based on conventional psychopathology coupled with learning theory. Both approaches focus on the "here and now" and on alleviating symptoms. Particularly in the 1980s, the two approaches merged through the launching of cognitive-behavioural therapy (CBT), which largely comprises an integration of BT and CT with insights from recent cognitive psychology and social and cognitive learning theory (Hawton 2009; Bennet-Levy 2008; Rachman 2009, 17). CBT develops the underlying concept of CT that we learn core beliefs about our self, others and the world and that thoughts play a fundamental role in our feeling and behavior. At the turn of the millennium, this led to the specification of a five-area model (Williams 2001).

Figure 1. Five-area CBT model (www.gp-training.net):



Thus, certain situations in the environment may activate certain pathological interplays between levels of thought, behaviour, mood and physical functions (Padesky 1995, 5). The CBT approach operates with more levels of thinking and more areas of the psyche than the CT approach and it focuses on how maladaptive patterns are not only maintained by cognitive dissonance (illogical thinking) but also by dysfunctional life strategies and behaviour (e.g. avoidance):

Figure 2: CBT-model with compensatory life strategies (www.galwaycounselling.org)



Like BT and CT, CBT is based on learning theory and focuses on patterns of responding to problems and situations. The main idea of CBT is that people may respond appropriately and adaptively or inappropriately and maladaptive to situations depending on their learned way of thinking and acting.

As in BT and CT, the basic idea is that psychopathological phenomena are a product of the learning of dysfunctional structures and patterns. The first step in CBT is therefore to teach the client to become aware of thoughts, actions and feelings, and the situations that trigger negative thoughts and behavior. Therapeutic intervention is a corrective learning process that now combines cognitive and behavioural strategies. All these strategies can be described as learning-oriented in the context of a clinical-educational method. They focus on the present, engaging specific problems by making the client unlearn dysfunctional and maladaptive patterns of thinking and behaving, and learn functional and adaptive skills and ways of thinking and behaving in relation to his/her life situation.

Therefore, in CBT the therapeutic relationship is often characterized as educational rather than medical. The therapist is either directive and teaches the patient, or collaborates by guiding or assisting the patient (McLeod 2003, 141). However, the CBT model of therapy is an educational learning approach based in a medical model. It conceives mental disorders as maladaptive patterns that are psychopathological dysfunctions with pathological symptoms. The therapist must diagnose and treat the maladaptive patterns clinically in order to achieve the goal of healing, i.e. normalizing mental health. The development of CBT has been influenced by its application with particular mental disorders and presenting issues, such as depression and anxiety. As in BT and CT, the CBT-approach also includes a strong emphasis on measurement in assessment, treatment and outcome, and it places an emphasis on experiments and evidence-based research.

2.3.4. Facilitation of learning in CBT

CBT is oriented towards faulty cognition and behavior, and the overall strategy of therapy is to target this deficiency through a corrective learning process. Rosenberg subdivides this therapeutic strategy into three sub-ordinate strategies:

(1) A *psycho-educational strategy,* aiming at educating the client about his or her mental problem.

(2) An *insight contracting strategy*, with the aim that the client obtains a better understanding of his or her mental processes.

(3) A *problem-solving* or *coping strategy,* aimed at teaching the client new capabilities and new ways of thinking and acquiring more effective ways of coping with problems (Rosenberg 2007, 244).

In practice, CBT begins with the initial contact between therapist and client. The assessment of maladaptive patterns and corrective facilitation of adaptive learning in CBT relies on establishing a strong collaborative therapeutic alliance between the client and the therapist. Thus, CBT emphasizes the importance of relational dynamics as well as the behavioural and cognitive aspects of the client's representation. The therapeutic relationship in CBT is characterized by empathy, warmth and genuineness (Beck 1979, 21). At first, the therapeutic relationship is likely to be one of tutor-coach or teacher-student and the therapist may take more responsibility and control and be more active. Gradually, the relationship evolves towards a consultative mode, and responsibility and control are handed over more to the client (Willis 2008, 9).

Initially, the therapist will focus on setting the agenda, accessing the client's maladaptive patterns, arriving at a diagnosis, and developing a formulation of the problem and goals for therapy. CBT is agenda-driven, so the therapist introduces an agenda for future sessions and begins each session with organizing statements (Wills 2008, 30-1). Problem formulation and goal setting involves developing a shared understanding of the problem and agreeing specific goals with the client. According to Dudley and Kuyken this formulation consists of explaining the clients' presentations in a theoretically informed way by integrating the client's unique experience with the theoretical framework of CBT, which draws on clinical and educational principles (Dudley 2014). In CBT, case formulation is closely linked to psychoeducation, where the therapist educates the client about the rationality and procedures of CBT as well as about the clients' clinical problem, e.g. anxiety and avoidance (Leahy 2004).

The next step for the therapist is to instruct clients to learn more adaptive thinking, and to teach coping strategies. For this purpose, the therapist employs a wide range of specific therapeutic

techniques: Verbal techniques, like questioning with testing and disputing, information giving and analogies; imaginary techniques, like imaginable generating and rehearsing alternatives, evaluating change and distraction; and behavioural techniques, like activity-scheduling, self-monitoring, social skills and problem-solving training (Wills 2008; Leahy 2004; Trower 2010; Padesky 1995; Hawton 2009; Clark 2009). Some of the therapeutic work in CBT has to be carried out as homework tasks by the client between sessions, which are reviewed subsequently with the therapist, for example thought recording in schemas and behavioural tasks. The therapist follows the client's instructive learning of adaptive skills by supporting the client as he or she applies the new skills in their everyday lives.

CBT tends to be short-term and only lasts as long as necessary to get the client on track towards their goals. Therapy ends when the client is satisfied with their change and understands what they need to do without therapy.

2.3.5. Educational objective of CBT

The objective of CBT can be formulated in clinical as well as in educational terms. The clinical objective of CBT represents both the intended clinical outcome from the therapist's position, and the hypothetical clinical outcome in the theory of CBT. The clinical objective of CBT is to focus on mental problems like depression and anxiety and treat them by alleviating current distress and pathological symptoms. The educational objective of CBT represents the intended learning outcome from the therapist's position, and the hypothetical learning outcome from the theory of CBT. The educational objective of CBT is to help clients to change the way they think, feel and behave so that they can think, feel and behave in more adaptive ways in response to given life situations and events. Thus, the objective is that clients unlearn maladaptive skills, strategies and patterns of

thinking, feeling and behaving and learn adaptive cognitive and behavioural skills and strategies for coping with a more positive sense of self and ability to succeed in life.

2.4. Existential theory of learning and existential therapy (ET)

Existential theories of learning and existential therapy (ET) are based on an existential-phenomenological approach that takes 'existence' rather than behaviour and/or cognition to be the basic dimension of the human way of being. This means that knowledge and truth are always understood in the light of an experiential and fundamental analysis of the subjective human being-in-the-world and therefore in the specific situation and context.

I will look at correlations between existential theory of learning and theory of ET. My aim is to clarify the role which learning assumes within ET.

2.4.1. Existential theory of learning

The most widely used and accepted existential theory of learning was developed by Colaizzi. Colaizzi's existential understanding of learning involves an alternative to the traditional focus in educational psychology on universalistic and essentialist conceptions of human development associated with scholastic teaching. According to Wackerhausen, it is implicit in the scholastic paradigm of knowledge that learning is a subject's acquisition of external knowledge, and that the individual is an isolated information processor (Wackerhausen 2004, 220).

According to Colaizzi, traditional educational psychology therefore defines and measure learning as a progressive development of performance (Colaizzi 1998, 186). As a supplement to such conceptions of learning as a measurable and quantifiable phenomenon, Colaizzi posits the concept of *genuine learning* as an activity in which the learner extracts the contents of material that gives him/her a new meaning of reality. Thereby the learner has the experience of learning something experienced as being true to him/her (Colaizzi 1998, 195). In other words, Colaizzi perceives traditional learning and genuine learning as two different types of learning processes and outcomes.

As in cognitive theory, learning is therefore an active process. However, Colaizzi's theory is an existential phenomenology of learning that is not interested in cognitive learning as a change of cognitive capacities and structures. Instead, it deals with existential learning as a personally and bodily experienced restructuring of the learner's Being-in-the-world through which the learner's existence is changed in essence (Colaizzi 1998, 201). Hence, the core of the learning content is meaning in relation to our lives, and learning is a reflective process that requires us to make an existential choice. Thus, learning may be a painful process that challenges our current thinking and behaviour patterns. Colaizzi also describes the genuine learning process as a movement towards the authentic self, as an authentic process of separation that requires us to put something at stake and restructure our world by existentially transforming our life and taking responsibility for our own existence. Existential learning is individual and is associated with taking responsibility for life. Thus, learning outcome of the existential learning process may be articulated as authenticity achieved through an existential transformation of self and life. Learning and existence are therefore interconnected and Colaizzi distinguishes existential learning from *programmed learning*, (Colaizzi 1998, 205). Programmed learned defines a performance directed acquisition of knowledge and skills, of competencies, that perceives the individual as an information processor.

2.4.2. Existential therapy (ET)

I have already referred to Cooper's description of ET as including a variety of different existential approaches to therapy. The question is how I define the objective of ET in my project.

Firstly, according to Cooper, some key dimensions are shared across the different existential approaches to therapy (Cooper 2009, 139). Among other things, Cooper describes how the common aim of therapeutic work is:

> *"...to help clients become more authentic: to become more aware of their actual existence, and to live more in accordance with their true values, beliefs and experiences"* (Cooper 2009, 139).

We can see that there is an overlap between the general objective of ET and Colaizzi's theory on the outcome of genuine learning.

Secondly, in order to provide a more detailed account of this objective, we must also take into account that we can identify a number of differences across the different existential approaches to therapy. In this project, I will only focus on the British School of Existential Analysis.

According to Cooper, the British school has a diverse approach, mainly represented by Cohn, Spinelli and Deurzen. The British school tends to reject the medical model of mental health and it avoids viewing clients through clinical categories and diagnoses (Cooper 2009, 109). Instead, the British school perceive clients as having *problems with living*, which all human beings may face. Therefore, the British school rejects the idea that therapists should help the clients towards *normality* or *mental*

health. Rather, the therapist helps the client to find their own unique way of being and therapy rests on an egalitarian relationship between therapist and client.

- The work of Spinelli represents the most phenomenologically-oriented part of the British school. Spinelli understands ET as a direct expression of phenomenological research. This bestows a centrality upon the relationship between the therapist and the client (Spinelli 2007, 57-59). Furthermore, he describes how clients place the greatest significance on experiential and existential outcome-dimensions (Spinelli 2007, 54). The aim of ET is to help the clients examine, reflect on and clarify their way of experiencing their being-in-the-world, so that they can truly choose this way of being or choose to undergo a transformation.

- Cohn has a slightly more existential approach to ET. He describes how the objective of ET is not mainly the elimination of symptoms because ET perceives the symptom as an important aspect of the patient's total situation. Rather the objective of ET is "the emergence of a more authentic way of living" (Cohn 2009, 122). Furthermore, Cohn defines authenticity as an openness to existence that involves an acceptance of what is given along with a freedom to respond to it. He also states that the concept pair of authenticity and inauthenticity must not become another measure of psychological wholeness (Cohn 2009, 127).

- Deurzen has an even more existential approach to ET and describes the object of ET as *dilemmas of living* (Deurzen 2008, xiii). According to Deurzen existential problems and mental suffering are not caused by psychological or physiological dysfunctions but by a *misguided philosophy of life* that leads to experiences of meaninglessness (Deurzen 2008, 17; 2009, 19). According to Deurzen, the most basic challenge of life is not to overcome or eliminate but rather to accept and make creative use of the very paradox involved in living

(Deurzen 2008, 18). Human beings have no innate ability to handle this task but have to *learn* it through experiencing encounters with the world. Similar to Colaizzi's explanation of the existential learning process as demanding and painful, Deurzen describes how clients must learn living through reflective experience (Deurzen 2008, 7). In other words, the aim of ET is not a medical goal of curing or healing but an ethical goal of learning to live with greater expertise. Thus, Deurzen explicitly describes ET as a learning process and how being a client is about learning the skills of living more resourcefully and having the courage to be more present and engaged in life (Deurzen 2011, 137).

2.4.3. Existential therapy as process of learning

I will follow Cooper and argue that, in various ways, these theorists of the British school share the general idea that the objective of ET is to help clients become more authentic, aware of their actual existence and live in accordance with their true values, beliefs and experiences. This objective is consistent with Colaizzi's understanding of genuine learning as a progressive movement towards a more authentic life, which involves the learner's experience of meaning in existence. Thus, the educational objective of ET is to assist the client to become more authentic, aware of their actual existence and live in accordance with their true values, beliefs and experiences in relation to themselves, others and the world. In accordance with Colaizzi, this existential learning process takes place at the level of an existential transformation of the client's life, and is experiential (Colaizzi 1998, 139). Likewise, Deurzen articulates therapy as a learning process where the client must acquire the skills for living more resourcefully along with the skills for using therapy, and that anxiety is an inevitable part of learning (Deurzen 2011, 137-43).

2.4.4. Facilitation of learning in Existential therapy (ET)

ET is based on the establishment of a strong therapeutic relationship between therapist and client (Spinelli 2007, 59; Cohn 2005, Ch. 5). Thus, the British school perceives the therapeutic encounter as the focal point for the clients' development. The therapist must be able to meet the unique client by establishing a mutual relationship that provides the framework for creating a space from which the client can learn to live more resourcefully and authentically (Cohn 2005, 33; Deurzen 2011, 137; Spinelli 2007, 59). Therefore, the therapist must be able to form a dialogue with the client, with a focus of staying with and presently attuning to the client.

Facilitation of learning in ET is based on an exploration of the client's world-design or world-views. According to Deurzen and part of the British School, there are four simultaneous ways of Being-in-the-World and the client experiences her or his existence in relation to her- or himself, others, nature and the spiritual world (Deurzen 2008; Adams 2013; Langdridge 2013). Differently, Spinelli identifies three substructures; the self-construct, the other-construct and the world-construct (Spinelli 2007, 33). Spinelli is very inspired by the phenomenology of Husserl as well as by the social constructionism of Gergen (Cooper 2009, Ch. 7). Far more than Deurzen's position, Spinelli's phenomenological and constructionist position is close to a cognitive approach.

In general, ET asserts that anxiety is an ontological condition that underlies the structural make-up of all the clients' assumptions and worldviews (Langdridge 2013, Ch. 5).

According to Deurzen, clients can only benefit from ET if they feel able to go along with the principles and procedure of the existential approach (Deurzen 2007, 2). Thus, in order for clients to benefit

from ET they must be able to learn and accept the capacity for making well-informed choices about their own lives and their attitude towards it.

The existential therapist does not employ specific therapeutic techniques, but rather skills based in basic existential and phenomenological principles (Spinelli 2007; Deurzen 2011; Cooper 2012). Therefore, themes like freedom, meaning, values, goals, and beliefs play an essential role for the existential approach. The therapist assists the client in exploring the clients' existential dimensions using questioning and a phenomenological method for staying with and being attuned to the clients' experiences. Hence, it is not the role of the therapist to be directive, specific of strategic but rather to be with the client or to help the client to find his or her own direction (Spinelli 2007, 108-110; Deurzen 2011, 69). It is also not the role of the therapist to be an expert or technician but rather to function as a mentor or facilitator. Consequently, the therapist mentors or facilitates the client in learning abilities and competencies for living more authentically, free and resourceful, with their own values and direction in life. This involves learning abilities for understanding and approaching dilemmas and tensions in life.

2.4.5. Educational objective of ET

ET tends to avoid the medico-clinical framing of therapy, and therefore it is difficult to articulate a conventional clinical objective of ET. However, ET may be articulated as a learning based and learning directed therapeutic approach. The educational objective of ET represents the intended learning outcome of ET from the position of the therapist and the hypothetical learning outcome involved in the theory of ET. The educational objective of ET is that clients undergo an existential

transformation and learn capabilities of living more resourcefully and with higher self-awareness in relationships with self, others and the world. This involves learning capabilities to be authentic, to be aware of ones' actual existence, to handle difficulties and to live with engagement, courage and freedom in accordance with one's true values, beliefs and experiences.

2.5. Theoretical comparison of CBT and Existential therapy (ET)

2.5.1. Conception of human being

Overall, whereas CBT in theory tends to conceive the human psyche in the technical and scientific terms of basic psychological functions of cognition, behavior and emotions, ET in theory tends to conceive human being in the holistic and philosophically derived term of existence as a Being-in-the-world (Christensen 2009). However, both approaches concern themselves with client's interpreted view of self, others and the world and conceive human beings in the fundamental term of life and therefore as a living human being encountering the conditions and challenges of life (Hickes 2012, 25-7).

2.5.2. Learning in psychotherapy

In theory, I may articulate both CBT and ET as learning directed therapies aimed at learning about living and self, others and world. However, the two approaches are based on different learning approaches. The approach of CBT is based on behavioural and cognitive learning theories that define learning as a relatively permanent influence on behaviour or cognition, which comes about through

experience (Santrock 2008). Thus, the educational objective of CBT is to bring about the learning of more adaptive behavioural and cognitive capabilities. In contrast, the design of ET is related to existential phenomenological learning theory that defines learning as a relatively permanent restructuring of individual existence, created through experience (Colaizzi 2004). Thus, the educational objective of ET is to bring about the learning of a more authentic being and existential capabilities for living. As such, the intended aim of learning outcome in CBT may be expressed in terms of achieving a more adaptive and healthier way of functioning, whereas the intended learning outcome in ET may be expressed in terms of discovering meaning and living authentically. That is, programmatic learning of functional capabilities for adaptive behaviour and thinking in the social environment, against in-depth learning of capabilities for individual authentic living in relation to oneself, others, nature and the spiritual world. However, both approaches emphasize the individual's reflectivity and responsibility for his or her own life, the ability to encounter difficulties and the opportunity to change his or her living conditions.

2.5.3. Therapeutic relationship and facilitation of learning in psychotherapy

ET and especially more recent approaches to CBT both stress the importance of the therapeutic relationship (Hickes 2012, 21). In CBT, the focus of facilitating the learning process is on a collaborative relationship where the therapist takes a very active role as a teacher, coach or consultant. The therapist assists the client by educating them on clinical problems; identifying dysfunctional assumptions and schemas; discovering alternative strategies for living; and promotes corrective experiences that lead to new capabilities (Hickes 2012, 22; Wills 2008, Ch. 3). Initially, the therapist is setting the agenda, but as clients get insight into their own problems, they must actively practice changing their thinking and actions. Since the motivation for change and the personal responsibility for the way of responding to events is crucial, the educational notions of choice and responsibility are important to CBT even though less central than in ET. Therapy is present-centered and very strategically oriented to specific mental conditions and structured around clear goals and specific techniques of therapy.

In ET, meeting in a mutual relationship is the focus of facilitating the learning process. The therapist take on the role of a mentor or facilitator for the client's exploration of their world-view, enhancement of self-awareness, discovering strengths and weaknesses, discovering values and goals for living, and uncovering capabilities for living (Deurzen 2011; Spinelli 2007). While CBT emphasizes the identification and unlearning of dysfunctional behavioral strategies and cognitive schemas and assumptions, ET puts more emphasis on encouraging the client to explore and thereby learn the ways in which they relate to themselves and their world. While CBT emphasizes learning of specific functional cognitive, behavioral and emotional skills, ET attaches more importance to the client learning their own personal life capabilities and answers to life’s challenges (Wills 2008;

Deurzen 2011). Put together, the facilitation of learning in ET does not focus on the unlearning of old schemas, assumptions and strategies and the strengthening of adaptive capabilities and acquirement of new capabilities. It rather focuses on uncovering, exploring and developing those assumptions, talents and values, which are already there, even though they may be deeply hidden (Deurzen 2011). Thus, the therapist follows the clients' agenda and assists the client in finding his or her own direction in life and the abilities to follow it through (Spinelli 2007; Deurzen 2011). However, both CBT and ET involve a focus on the clients' fundamental beliefs about the world and stresses the importance of emotions as providing a way to identify "underlying beliefs and values, and their associated meaning" (Hickes 2012, 25). In addition, both CBT and ET focus on the clients' fundamental beliefs about themselves, others and the world and seek to help the clients develop a new sense of their selves through exploration and the opening of new choices for the client (Hickes 2012, 25).

2.5.4. Life problems and the medical model

ET and CBT both focus on helping the client to identify difficulties in living related to beliefs, emotions and values (Hickes 2012, 25). However, the existential approach stresses that life problems are not manifestations of specific dysfunctions but expression of diverse difficulties in relation to coming to terms with life's challenges. People inevitably experience anxiety in the confrontation with the challenges of life and have a tendency to flee, lose themselves or get shut-up in themselves (Deurzen 2008; Spinelli 2007). This stance involves a rejection of the medical model and psychiatric classifications and diagnostics (Deurzen 2008; Spinelli 2007). Unlike the cognitive-

behavioral approach, the aim of ET is not to cure people or change their dysfunctional way of adapting to the world but help them learn a personal way of tackling life's problems (Deurzen 2011).

CBT tends to perceive certain life problems from a medical framework and "offers models for treatment of a range of specific psychiatric diagnoses" (Hickes 2012, 21). CBT tend to focus on unlearning maladaptive and pathological patterns and learning more adaptive and healthy patterns with curing through a relief of pathological symptoms (Hawton, 2009).

2.5.5. The active and reflected client

Both approaches stress the importance of the here-and-now encounter and places emphasis on the clients' ability as a reflective and acting being (Wills 2008; Spinelli 2007; Deurzen 2011). Rosenberg points out that the existential approach makes up part of the foundation of CBT, in so far as it emphasizes the individual's possibility of developing, planning his or her existence, reflecting on his or her self and making choices, and it focuses on the subjective experience of the self (Rosenberg 2007, 247). The most significant difference is the focus in CBT on learning rather specific capabilities for thinking, acting and feeling and the focus in ET on learning authenticity. Thus, on a theoretical level there are many differences between the two approaches but also many similarities.

2.6. Research questions

My study is about the learning outcome of psychotherapy, with a focus on the lived experience of each approach for the client, emphasizing how people learn and what it is they learn in each of the different approaches.

The central research question is:

- *What is the meaning, structure and essence of the lived experience of the outcome of CBT and ET?*

This central research question is divided into the two research sub questions:

1. *In what ways is the choice of therapeutic approach active or passive and what significance does the motivation for the choice have?*

2. *In what ways has the client's participation in therapy helped to enhance learning for the client?*

Furthermore, the research question is followed by the theoretical sub question:

- *Is there a difference in the lived experience of the learning outcome of existential therapy and cognitive-behaviour therapy?*

2.7. Joining research questions and research objectives

The research questions are coupled with the research objectives. The research objective are active statements about how the study is going to answer the specific research questions. The research

objectives define the specific aims of the study. From my central research questions, my research objectives will focus upon people's understanding of their lived experience of the outcome of CBT and existential therapy. From my first research sub questions, the research topic may be outlined as the understanding of the lived experience of the motivation for the choice of therapy in CBT and existential therapy. From this, the first overall objective can be stated as follows:

1. To explore the significance of the motivation for the choice of therapy for the understanding of the lived experience of the learning outcome

From my second research sub question, the research topic may be outlined as the understanding of the lived experience of the enhancement of learning in CBT and existential therapy. I will limit this topic to a specific geographical area, which is Denmark. From this, the second overall objective can be stated as follows:

2. To explore the understanding of the lived experience of the outcome in CBT and existential therapy in Denmark and the ways in which it involves an enhancement of learning.

From my theoretical sub-question, the third overall objective can be stated as follows:

To explore differences and similarities in the understanding of the lived experience of the learning outcome of existential therapy and CBT. I have made a research schedule joining the research objectives and research questions in Appendix 0A. I have made a timeline of the research project in Appendix 0B.

Chapter 3. Methods and procedures

This chapter will include the factors, which have influenced the choice of methodology for this research. Following this, the approach of Interpretive Phenomenological Analysis (IPA) will be explored. Then, the arrangement of research procedures in line with IPA will be clarified and accounted for.

3.1. Choice of methodology

The choice of methodology for this study is based on qualitative methods that were weighed against quantitative methods. Because the study is concerned with lived experience, it will take the form of qualitative research. Thus, the study is connected to an idiographic concern for the exploration of subjective meaning and lived experience.

My research involved choosing amongst different qualitative research methods. Firstly, I did not choose discourse analysis for the study. The main reason for choosing discursive methods is that the researcher assumes language to have a constitutive role and that the researcher believes discourse to be central for the negation of a shared social reality (Willig 2008, Ch. 6). Discourse analysis would be a relevant choice if I were interested in investigating how participants use discursive resources and with what effects. Thus, my research could address the issue of the way personal accounts of meaning are constructed in social relationships like the therapeutic relationship, how the power relation in psychotherapy show up in discourse or how individuals take up particular subject positions in psychotherapy. My research could also address the issue of the way personal accounts of mental distress or problems are constructed in certain social or cultural

context. For example, existing research studied the linguistic and dialogical features of episodes of therapeutic change and ruptures of the therapeutic alliance (Martinez 2012). Other research studied the negotiation a pathological identity in the clinical dialogue (Avdi 2005). However, discourse analysis is not the proper choice for an exploration of how individual participants understand and make sense of their lived experience of the outcome of psychotherapy.

Secondly, I did not choose grounded theory for the study. Grounded theory is designed to facilitate the process of theory generation through identification and integration of categories and meaning from data (Willig 2008, Ch. 3). A good reason for choosing grounded theory is that I want to develop middle range theories that help explain under-theorized areas of human experience. That I want to keep my own interpretative activity at bay. That I want to develop progressive hypotheses and minor theories, or I want to delay the literature review until I develop my own research hypotheses. For example, I could study how clients experience the change process in psychotherapy or the experience of the therapeutic relationship from the point of view of the clients. Amongst other things, existing research has studied clients' perceptions of pivotal moments in couples therapy; clients' experience of disengaged moments in psychotherapy; and clients' experience of sadness in psychotherapy (Henretty 2008; Helmeke 2000; Frankel 2008). However, grounded theory is not the proper choice for an exploration of how individual participants understand and make sense of their lived experience of the outcome of psychotherapy in terms of learning.

Thirdly, I did choose a phenomenological approach for the study. However, I did not choose descriptive phenomenology, which I will deepen in the following sections. The main reason for choosing descriptive phenomenology is that the researcher wants to obtain a concrete description of a psychological phenomenon of interest and articulate the general structure of the experience of

the phenomenon. For example, I could study how clients essentially experience psychotherapy. Examples of existing research includes studies of the essence of the lived experience of learning and/or memory (Colaizzi 1973; Giorgi 1989). However, descriptive phenomenology is not a proper choice if I want to explore how individuals understand and make sense of their lived experience of the outcome of different psychotherapeutic approaches, and how far it makes sense to understand this experience in terms of learning.

Since the aim of the research is to explore the meaning, structure and essence of the outcome of CBT and ET in the experience of participants and their understanding of these experiences, the qualitative nature of the IPA analysis was found especially useful. Hence, my research seeks to capture the participants' unique way of experiencing and understanding the outcome of CBT and ET in possible terms of learning through the detailed description provided during the interviewing process. IPA was chosen for the study in order to gain a better understanding of the quality of the experience of the learning outcome of CBT and ET presented by the participants, which was then explored by the main researcher and reflected through the researcher's understanding of the phenomenon (Willig 2008).

In the following sections, I will deepen my choice of research methodology.

3.2. Qualitative Research

Research methods and research data in psychotherapy and psychology can be positioned into two basic categories: qualitative research and quantitative research (Langdridge 2009, 13).

Quantitative research concentrates on gathering data in numerical form by counting occurrence and the size of association between entities, which can be put into categories, ranked or measured. Quantitative data are typically produced by research methods like experiments, observations and questionnaires that allow the data material to be transformed into numbers and categories (Langdridge 2009: 14). In other words, quantitative research functions mainly on a macro level and, applied to this research; it could possibly highlight the dynamic as well as the negative and positive outcomes of the effect of CBT and ET. However, I wanted to capture participants' unique and detailed way of experiencing the learning outcome of psychotherapy through a comprehensive and nuanced analysis.

In contrast, qualitative research gathers information that is not in numerical form and involves collecting the data in the form of natural verbal reports; for example, open-ended questionnaires or semi-structured interviews and unstructured observations. Qualitative data is typically descriptive data and therefore harder to analyze than quantitative data. This type of research is by definition exploratory and it tends to be concerned with meaning (Willig 2009, 8). Qualitative research is especially useful when we want to go deeper into issues of interest and explore nuances related to the problem at hand. Thus, we must choose qualitative research for studies at the individual level when we want to find out, in depth, the ways in which people think or feel. In other words, qualitative research has the ability to function at a micro level and thereby explore the underlying processes by studying the human being as an individual. Therefore, I have chosen it to investigate the lived experience of learning in psychotherapy and the understanding of this experience.

The study of people, in particular within psychotherapy research, requires a methodology to understand what is going on from within. Thus, I perceived Interpretative Phenomenological Analysis (IPA) as the most appropriate method of analysis with its emphasis on engagement, and involvement in participants' accounts and with the attempt of implementing an insider perspective rather than an objectivist stand (Smith 2010). I made the decision that IPA would be the best choice of method to capture the lived experience of the phenomenon of learning an outcome in psychotherapy. That is, with the acknowledgement of the interaction between the participants' account and the researcher's own interpretative stance and with the notion of understanding meaning, which is perceived as embedded within the referential totality of history and culture.

3.3. Phenomenology and hermeneutics

My research project aims to transform the way of thinking about the learning outcome of psychotherapy by shifting the emphasis away from theoretical objectives, therapy of hypothesis and clinical measurements and into experience. Hence, I perceive the outcome of psychotherapy as a personal lived experience, known only to the client, and phenomenological research is most suited as it seeks to explore the meaning of the lived experience for the client. Whereas scientific methods adopt an objectifying view of reality, phenomenology is more interested in subjective experience and the living of it. Thus, phenomenological researchers prefer first-person accounts of experience to abstract theoretical or general quantitative representations of those experiences. Via qualitative methods of description and interpretation, phenomenologists strive to identify the core features or qualities of human experience in such a way that they can inform the fields of psychotherapy and psychology. In this respect, one can argue that phenomenology challenges the notion of objectivity and its reductionist implications for making sense of human experience. Thus, phenomenology

attempts to embrace the complex interplay of consciousness, embodiment and context through which human experience may occur (Langdridge 2007).

Many researchers tend to differentiate between descriptive phenomenology and interpretive or hermeneutic phenomenology. My research will follow the hermeneutic line within phenomenology.

3.3.1. Transcendental and descriptive phenomenology

Originally, Husserl established the phenomenological approach within philosophy. His philosophical theories have paved the way for the application of phenomenology within psychotherapy and psychology. Especially, Husserl inspired descriptive phenomenology within psychology. The aim of descriptive phenomenology is to reveal the essential general meaning structures of the phenomenon (Langdridge 2007).

Husserl launched transcendental phenomenology as an approach aimed at describing our experiences of things in themselves, phenomena, without metaphysical and theoretical speculations (Husserl 2012). Philosophy should therefore have become a distinctive phenomenological science of intentional consciousness. This intentionality involves a correlation of what is experienced (noema) and the way it is experienced (noesis) (Husserl 2012, Ch. 3). In order to do this, philosophy needed to employ the method of epoché, involving a bracketing of presumptions and prejudices. Likewise, transcendental phenomenology is an attempt to look at particular examples without theoretical presuppositions before discerning the essence of pure experiences of things in themselves (Husserl 2012, § 75). Husserl also introduced the method of phenomenological reduction, which expands the principle of the epoché with the three key elements of horizontalisation, description and verification. Thus, Husserl's phenomenology is an

attempt to describe the experienced phenomenon within consciousness and verify its sense without producing a hierarchy of meanings.

Later, Husserl introduced the concept of the life-world, which refers to the world of experience as lived (Husserl 1970). That is, the lived world, which subjects may experience together, defined in contrast to the scientific world of object. Thus, whereas previously operated with a transcendental subject, he now states that the intersubjective community of people's consciousness is the foundation of all epistemological enquiries.

Descriptive phenomenological psychology is concerned with describing psychological phenomena in their appearance and finding the essence of the experience (Giorgi 1985). For the researcher to be open to phenomena that appear, the aim is to bracket previous assumptions or understandings about the phenomena investigated. Often this involves a study of the way such phenomena appear in the life-world. Then the task of the researcher is to bring out these dimensions and show the structural whole, which is both socially shared and experienced in particular ways (Finlay 2011).

3.3.2. Hermeneutic phenomenology

My research involves an interest in the subjective experience of reality. In this project, I will take into account how our experience of reality is mediated by our interpretations. The method I have chosen for this study, Interpretive Phenomenological Analysis (IPA), identifies more strongly with the hermeneutic tradition. Hence, IPA recognizes the central role played by the researcher and does not advocate the use of bracketing (Smith 2010).

Heidegger launched hermeneutic phenomenology with the ambition of modifying Husserl's theory of

phenomenology by integrating insights from existential and hermeneutic philosophy, especially Schleiermacher, Dilthey and Kierkegaard (Heidegger 2009). Heidegger argued that, contrary to Husserl's theory, it was not possible to investigate things in themselves, phenomena, in a neutral and detached way because human beings are fundamentally embedded in the world: Being-in-the-World (Heidegger 2009, §12). Furthermore, Heidegger states that any in-depth inquiry into the experience of phenomena must be informed by a fundamental understanding of what it is for human beings to exist. To Heidegger, the world in question is that fore-structure of meanings wherein a given human being might be said to exist. Heidegger describes the concept of the hermeneutic circle as the insight that our understanding of phenomena in the world is always grounded in a broader perception: the fore-structure. Thus, the hermeneutic process is a circle of self-reference that grounds our understanding of phenomena in a priori preconceptions. Therefore, every individual experience in everyday existence is situated within a whole, and likewise the whole is situated within every detailed individual experience in everyday life. This means that there is a complex relation between interpreted and interpreter. Because we are always involved in an interpretation of phenomena, there can be no interpretation that is free of preconceptions (Heidegger 2009, § 32). Therefore, the attitude that Husserl attempts to bracket becomes the very center of Heidegger's hermeneutic phenomenology. This attitude is perceived as the interpretative framework through which the world can be understood. In other words, since phenomena show themselves to us, our primary encounter with them can be nothing other than interpretative.

In my research project, I must take into account that my participants' experiences are interpretations of phenomena based on their fore-structures. Likewise, I must also take into account that as researcher I am always engaged in an interpretation and have preconceptions. Therefore, my research involves a reflection on my own position.

3.3.3. Hermeneutics

The method of choice, IPA, includes an even more advanced hermeneutic approach, launched particularly by Gadamer, who develops Heidegger's hermeneutics (Gadamer 1989, Ch. 3; Langdridge 2007, Ch. 4.1; Smith 2010, 25-7).

Gadamer expanded Heidegger's notion that the meaning of phenomenological description lies in interpretation, and he re-conceptualized the hermeneutic circle (Gadamer 1989, Ch. 4). Gadamer emphasizes how the circularity of interpretation involves that understanding is situated within a cultural and historical context (Gadamer 1989, Ch.4b). Gadamer perceives the circular process of interpretation as more dynamic than does Heidegger, and that the circular process involves the creation of a new understanding of the whole. Because of this, it is possible for the phenomenon to impact on the interpretation, and the interpretation may influence the fore-structure and vice versa.

According to Gadamer's hermeneutic approach, interpretative understanding is at the center of our existence as human beings. We understand the world through our language, which depends on our culture and history (Gadamer 1989, Ch. 5). This means that we make meaning of phenomena through our interpretative understanding, which always appears by means of our language. It is therefore determined by our pre-understanding that involves certain preconceptions or prejudices. Therefore, our understanding is both made possible and limited by our pre-understanding. Furthermore, all interpretative understanding takes place within our horizons. According to Gadamer, when we attempt to make sense of anything (or anyone), we also do so by virtue of our own horizon of understanding. Therefore, as part of the meaning making up our interpretative understanding are dialogues or conversations between something old and something new.

As our pre-understanding and horizon might be changed or expanded over time, it is by its very nature inseparable from understanding, since any effort to set aside or reject one's bias and outlook is likely to ignore or repress the impact of that bias and outlook.

According to Gadamer, dialogue and conversation is at the core of understanding. It is through conversation between people or between people and texts that the world reveals itself as a shared understanding of phenomena. To understand something is to reach an understanding with another about it, and that can only be achieved through a conversation that sustains the interplay of question and answer (Gadamer 1989, 368). In such a dialogue, the participants acknowledge consensus in their particular worldviews and their individual horizons fuse (Gadamer 1989, 306).

My project tries to make sense of the meanings of experiences of learning outcomes to the participants themselves. This involves a double hermeneutic in which I am trying to make sense of the participant trying to make sense of the learning in psychotherapy. Thus, as the researcher, I will engage in an interpretation of the participants who are also engaged in an interpretation, and several levels of dialogues are implicated. Through the interview, we will engage in an attempt to gain some kind of mutual understanding with an interplay of questions and answers.

3.4. Interpretative phenomenological analysis (IPA)

This study adopts the interpretive phenomenological perspective. The aim is to *explore both the participants' lived experience from their perspective and what this experience means for them.* As such, the focus is on experience of the life world. Smith launched IPA as a hermeneutical and phenomenological inspired research method within the field of psychology that could capture the

qualitative and experiential dimension of research (Smith 2010). IPA holds a hermeneutic phenomenological stance, which attempts to understand that people's relations with the world are interpretive and that they will concentrate on their attempts to make meaning out of their activities and the things that happen to them. The focus of IPA is on the lived experience of participants and it concerns itself with the way in which human beings make sense of their experiences of life.

The method of IPA combines phenomenology and hermeneutics with an idiographic and non-reductionist interest in human experience (Smith 2010, 29). This means that IPA argues for a focus on particular phenomena, experienced from the perspective of particular individuals in certain contexts.

IPA emphasizes engagement and involvement with participants' accounts and it attempts to adopt an insider's perspective rather than an objectivist stance (Smith 2010). IPA is influenced by symbolic interactions with an emphasis on interpretation and with the aim of capturing the participants' experiential lived experience instead of an objective truth. In this respect, the researcher is perceived as an insider and not a detached observer.

IPA is informed by an antirealist epistemological position insofar as it relates the world to our conscious experience of it. This method takes into account that the participants' experience is never directly accessible to the researcher. Therefore, the approach always recognizes the way in which the researcher interprets the participant's experience (Willig 2009, 57). Thus, IPA acknowledges the interaction between the researcher's own interpretative stance and the participants' account. Consequently, IPA includes a critical reflection on researcher positioning.

3.5. Quality in IPA

The assessment of the quality of qualitative research is important. Smith emphasizes that qualitative research should be evaluated in terms of criteria that are appropriate to it (Smith 2010, 179). For IPA, Smith recommends the use of Yardley's four principles for assessing the quality of qualitative research (Smith 2010, 180-3):

1. *Sensitivity to context*

   Yardley recommends a demonstration of sensitivity to context. Firstly, I have attempted to demonstrate this sensitivity in early states by addressing the existing literature on my research topic. Secondly, I have attempted to demonstrate a sensitivity to the interview situation by employing my interview skills, awareness and dedication in the interviews. I have also made sure to show empathy and make the participants feel at ease in the interviews. Finally, I have demonstrated a sensitivity to the material obtained from the participants by using a considerable number of verbatim quotes and extracts to support my arguments. I thereby give the participants a voice in my thesis.

2. *Commitment and rigour*

   Yardley also recommends a demonstration of commitment. I have demonstrated this by conducting careful in-depth interviews with participants and have conducted a thorough and systematic analysis of the data.

3. *Transparency and coherence*

I have followed Yardley's principle of transparency by clearly describing the stages of my research process in my write-up of the study. I have described the elements of the analytic process and the selection of the participants.

4. *Impact and importance*

Finally, Yardley stresses that the real test of quality lies in whether it tells the reader something important. I have made sure to stress the importance of my research in my introduction as well as conclusion.

Within IPA, good analysis is perceived as analysis that balances phenomenological description with insightful interpretation, and which anchors those interpretations in the participants' accounts. Following Smith, IPA involves a process of analysis from the descriptive to the interpretative through a detailed procedure (Smith 2010). Thus, IPA does not seek to claim findings objective. However, IPA involves a preference for concentrating on themes and connections that are available within the text rather than attempting to fit the research into a particular pre-existing theoretical viewpoint.

3.6. Sample and recruitment

This study comprised of two groups consisting of six research participants each, one group of participants who were in ET and one group of participants who were in CBT. The study addressed the learning outcome of short-term therapeutic experience. In order to enable a comparison between CBT and ET, the study made sure that both methods were applied to the participants for

equal lengths of time, between twelve and fifteen sessions. The study only recruited participants who had sought therapy voluntarily and not been referred. Participants have only been recruited for the study if they have been clients to either cognitive-behavioural therapists or existential therapists that are working in line with the British school.

The last part was not difficult, as there is no uniquely Danish approach to ET and the majority of existential training institutions and existential practitioners in Denmark work in line with the British school. The continental European schools of Daseinsanalysis and Logotherapy and the American school of Existential-Humanistic Psychology have never gained any real ground as independent approaches or a basis for training institutions in Denmark. Conversely, the British school, and especially the works of Spinelli and Deurzen, has been popularized within the existential community in recent years. Danish psychologist Jacobsen has developed his own approach to existential psychology (Jacobsen 2008). Yet, this is a psychological and not a psychotherapeutic approach and Jacobsen has not founded his own school of existential therapy.

CBT is highly recognized and is the most widespread approach to psychotherapy in Denmark. Danish therapists working within CBT mainly take inspiration from the international trends within the field, and there is no specific Danish approach to CBT.

The researcher recruited the participants from registered cognitive behavioral therapists or existential therapists and from societies and forums for CBT and ET. In some cases, the participants were recruited directly from registered therapists, in others from announcements in societies and internet forums for CBT and ET. Three participants came forward after their therapists asked them to participate as a result of my direct request to registered therapists. Nine participants came forward after they or their therapist saw my advertisements in the societies and internet forums for

CBT and ET. In each case, I double checked with official registers and sources of information that the clients have been in therapy with therapists who are either working specifically within the CBT approach or specifically in line with the British school of Existential therapy. In some cases, I politely rejected potential participants, because they did not meet the criteria that were set up. Four potential participants came forward but after emailing them, it became apparent that neither of them had 12-15 sessions of CBT or ET and therefore did not meet the criteria. I kept no information on the therapists, as the focus of the research was not the specific therapist but the client's experience of the therapeutic approaches.

3.7. Data collection

My research project base on a wish to explore the meaning and understanding of the experience of the outcome of psychotherapy for clients from CBT and existential therapy. In-depth interviewing is a widely accepted method of data collection in IPA. The specific research method was informal, semi-structured interviews. I used an interview guide to support the discussion (Appendix 1).

I designed the interview guide to provide the participants with an opportunity to answer the research questions (Smith 2010, 61). Thus, the topics of the interview questions relate to the research topics; to the theoretical conception from my literature review; and to the subsequent analysis (e.g. Kvale 1996, 129). I started with identifying broad areas, which I hoped to hear about from my participants. Then I found a range of topic areas that I wanted my interview to cover. The interview guide shows the topics and their sequence in the interview.I made a schedule with ten topics of interview questions along with possible prompts. The purpose of semi-structured interview is to maximize rapport between interviewer and participants. I made sure to choose open formulations of questions that did not make too many

assumptions about the participants' experience, manipulate the participants or lead them towards particular answers. I used initial questions of this type: "Can you tell me something about…?" I also used structuring questions of this type: "Can we talk about…?" The purpose of these questions was to make the participants give a rich and detailed account of their understanding of lived experiences that relate to the research topic. Furthermore, I used follow-up and probe questions to explore and develop interesting leads and specifying questions to inquire into situations and examples, which allows the participants to recount descriptive episodes or experiences.

1. The first section of the interview guide

Because the aim of this research project is to make a comparison, it was important for me to clarify how the participants had chosen their modality of therapy. It was also important for me to know what the participant's motivation for therapy was. Thus, one of the research sub questions regarded the client's motivation for the choice of modality of therapy. Therefore, I based the first part of the questionnaire on a phenomenological focus on motivation and decision-making. The interview questions focused on the dimensions that had brought the participants to decide to go into therapy, the participants' initial hopes and wishes for the outcome of therapy and the participants' psychological motivation for beginning therapy.

1.1. I would be important to clarify how the clients decided to go into therapy. The first interview questions focused on the complexity and details around the client's experience of their decision of therapy. I avoided direct questions to their choice of modality of therapy and rather focused on questions that allowed the participants

to tell their own story and recount situations, experiences, actions and conversations with others that mattered to their decision.

1.2. I will also be important to clarify how the clients' initial notions, expectations and hopes influence on the decision of therapy and the choice of modality. It was important to explore whether these factors are a source of motivation. They may also influence the process and outcome of therapy (Cooper 2008; Frank 1991). Thus, the second topic regarded ideas, hopes and expectations for the outcome of therapy.

1.3. It seemed important to clarify, how the clients understood their experience of their own psychological motivation for therapy and how this motivation might have changed during the course of therapy.

2. The second section of the interview guide

The central research question regards the meaning, structure and essence of the lived experience of the outcome of CBT and existential therapy. This relate to the sub question about the ways in which the client's participation in therapy helped to enhance learning for the clients. I based the construction of the second part of the questionnaire on a phenomenological focus on learning through any experiential changes that occur in the participants because of the therapy in which they participated (Colaizzi 1973, 45-6). That is, with a focus upon learning as people's changed understanding of phenomena and their understanding of their experiences of these changes (Broberg 2000, Ch. 4; Smith 2010, 47). Furthermore, I took inspiration for the production of the interview schedule from

Burnett's suggestion to categorize the experiential learning outcome of counselling in terms of three broad areas of learning: Self, Relationships with Others, and the Process of learning and change (Burnett 2000). Thus, the second section of the interview guide focused on the ways in which the client's participation in therapy had helped to enhance a learning outcome for the client in terms of the participants self, relationships with others, and the process of learning and change, and learning potentials and barriers from therapy. As there does not exist a universal conception of learning, I also took inspiration for my interview schedule from the conceptions of behavioural, cognitive and existential learning in CBT and ET. This involved changes in the participants' relation to themselves, capacities to deal with life and difficult situations, relationships with others, options and participation in life.

2.1. Literature suggest that the learning in psychotherapy and counselling may involve learning about self. Burnett suggests that counselling involve learning about self: Self-awareness and self-acceptance, personal change, personal growth and development and personal world-view (Burnett 1998, 11). My literature review shows that on a theoretical level, existential learning in therapy may involve transformation of the self and increase of authenticity and self-awareness. My literature review also shows that on a theoretical level, cognitive and behavioural learning in therapy may involve learning a more positive sense of self. Thus, it was important to explore, whether clients experienced any changes in the ways they understand and relate to themselves.

2.2. My literature review shows that on a theoretical level, learning about self involves learning about life: Change in behaviours, actions, reactions and values, beliefs and

life direction (Burnett 1998, 11). On a theoretical level, existential learning in therapy involves learning about values and direction in life, talents and living resourcefully. On a theoretical level, cognitive learning in therapy involves a changed way of thinking and acting in life. Therefore, it was important to explore if and how clients experienced any changes in their ways of thinking, acting and reacting. It was also important to explore how the clients understood their own values, and if and how they had experienced any changes.

2.3. Literature suggests that learning about self in counselling involves learning new ways of coping and management or regulation of feelings (Burnett 1998, 11). On a theoretical level, both existential, cognitive and behavioural learning involves a changed way of approaching difficulties and difficult situations in life. From this, it seemed important to explore how the clients understand their way of coping with difficulties and if they had experienced any changes.

2.4. Literature suggests that counselling involves learning about relationships with others: Awareness and acceptance of others, insight into relations with others, self and others and growth of relationships (Burnett 1998, 12). Theory on existential therapy suggests that existential learning includes learning separation and learning to be in relationships to others. Theory on CBT suggests that cognitive and behavioural learning involves learning social skills and adaptive perspective on others. From this, it seemed important to clarify if and how clients have experienced any changes in their relationships to others and how they understood these changes.

2.5. According to my literature review, theory on CBT and existential therapy suggests that learning involves learning about living and ways of approaching life problems.

CBT stresses learning of adaptive ways of coping with difficulties. Theory on existential therapy and learning points out that existential learning involves learning to make choices and take responsibility. Thus, it was important to explore if and how participants experienced changes in their options to life and how they understood these changes.

2.6. My literature review shows how theory suggests that learning involves a changed way of understanding the world and/or being in the world. Theory on CBT suggests that learning involves abilities for adaption to the world and more adaptive assumptions about the world. Theory on existential learning suggests that existential learning involves a restructuring of the participants' being-in-the-world. Theory on existential therapy suggests that existential learning involves changes in participants' engagement in the world. Thus, it seemed important to explore if and how participants experienced any changes in their way of taking part in the world, communities and hobbies and how they understood these changes.

2.7. Finally, literature suggests that counselling involves a learning outcome on the process of learning and change: Insight into nature of learning and change, knowledge and skills that facilitate learning and change; understanding of the self as a change agent; and generalization of learning and change process (Burnett 1998, 12-13). Thus, it seemed important to explore if and how the participants experienced any other learning potentials and barriers in therapy. With a focus upon how participants understood these dimensions. This also involved exploring whether therapy involved their experience of any profound changes. Finally, it involved the participants' evaluation of their learning from therapy.

I provided research participants interested in participating with an informational letter, a consent form and a copy of the proposed interview guide with the questions ahead of the interview. I also asked my participants where they would like the interview to take place, since a comfortable setting is important for participants. Thus, most interviews took place in my office or their therapist's office. Two interviews took place in private settings. I made sure that the setting was safe for all parties and free from interruptions.

At the beginning of each interview, I summarized the main principles of the interview guide. I made sure to emphasize that I did not have a pre-set agenda with the interview, that there was no right or wrong answers to the questions and that I was interested in their saying as much about the topic in detail as they would like to say. As an interviewer, I employed many of my therapeutic skills to make the participants feel comfortable and gave myself good time to listen to what the participants told me before picking up a new thread or asking a new question.

All interviews were voice recorded using a digital voice recorder placed between the researcher and participant. All the interviews lasted between 40-80 minutes, depending on the experience presented and pace of communication. The researcher transcribed each interview after the interview process.

All the interviews are originally in Danish. After transcription, the researcher translated each interview into English. This was a very time-consuming process as it took three months. Apart from time, the translation was unproblematic and straightforward as the structure of the Danish language is close to English. The data analysis was in English. It should be noted that the translation might

represent a further move away from the original expression of the participants. Therefore, it was important for me to listen to the interviews several times and re-listen to them just before I began the initial noting.

It is important to acknowledge that the spoken word is often very different from proper grammatical formations. After writing the thesis, Jonathan Turner performed professional proofreading of the thesis. However, the proofreader recommended that the original transcripts remained confidential, were not proof read and remained un-edited, as my translations were the primary source material. According to the proofreader, it would be unethical to change the transcripts and I followed this advice.

The transcription of interviews offered the researcher an initial deep engagement with the qualitative data. According to Smith, this is the first essential step that brings about the process of phenomenological analysis from a holistic perspective (Smith 2009).

For the purpose of this thesis, I have given each participant a fictitious name:

- *Interview 1 (I1)*

  The first interview was with Alma, a woman in her mid-40s. Alma had had 12 sessions of ET. Alma was a middle-age woman who appeared relaxed and smiling during the interview. There was a good atmosphere in the room.

- *Interview 2 (I2)*

  The second interview was with Maria. Maria was a woman aged 42. She had had 12 sessions of ET. Maria appeared calm. Maria seemed very reflective and concise in her way of talking and gave quite condensed answers. The interview had a steady pace in a

calm atmosphere.

- *Interview 3 (I3)*

  The third interview was with Martha. Martha was a 39-year-old woman. She had had 12 sessions of ET. Martha appeared calm. Martha seemed very reflective and thoughtful during the interview and there was a sense of an intense atmosphere with a very good connection.

- *Interview 4 (I4)*

  The fourth interview was with Niels. Niels was a young man aged 27. Niels had had 15 sessions of ET. Niels was very talkative and engaged and the interview was very long. Niels made an informed choice of ET based on a previous interest in Yalom, even though he did not choose a therapist inspired by Yalom.

- *Interview 5 (I5)*

  The fifth interview was with Karen. Karen was a young woman aged 25. Karen had had 12 sessions of ET. Karen was very relaxed during the interview and there was a good atmosphere in the room.

- *Interview 6 (I6)*

  The sixth interview was with Klara. Klara was a 35-year-old woman. She had had 12 sessions of ET. Klara seemed very relaxed during the interview, even though once or twice she got a little confused as she reflected on the questions.

- *Interview 7 (I7)*

  The seventh interview was with Anna. Anna was a woman aged 40. Anna had had 12 sessions of CBT. Anna was very calm and aware during the interview and talked at a steady pace.

- *Interview 8 (I8)*

  This interview was with Lea. Lea was a 46 year old woman. She had had 12 sessions of CBT. Lea was very calm and aware during the interview. Lea made an informed choice of CBT.

- *Interview 9 (I9)*

  This interview was with Svend. Svend was a man aged 46. Svend had had 12 sessions of CBT. Svend appeared smiling and calm throughout the interview.

- *Interview 10 (I10)*

  The tenth interview was with Thor. Thor was a man age 38. Thor had had 15 sessions of CBT. Thor seemed very calm but was not very talkative, but gave some very precise and thoughtful answers.

- *Interview 11 (I11)*

  The eleventh interview was with Sune. Sune was a man aged 42. Sune had had 12 sessions of CBT. Sune had a very calm way of talking with a deep voice and he seemed very aware and attentive during the interview.

- *Interview 12 (I12)*

  The final interview was with Carl. Carl is a man in his early 40s. Carl had had 15 sessions of CBT. Carl was very talkative and spoke quickly. I got the impression that this was Carl's normal way of talking, as he seemed very relaxed during the interview. Furthermore, he seemed very eager to talk and spoke for almost 80 minutes. Carl made an informed choice of CBT.

3.8. Data analysis

This study adopted the interpretive phenomenological perspective to *explore both the participants' lived experience from their perspective, and what this experience meant for them*. However, interpretive phenomenological analysis (IPA) takes into account that this experience is never directly accessible to the researcher. Therefore, the approach always recognizes the way in which the researcher interprets the participant's experience (Willig 2009, 57).

Studies conducted according to IPA are always inductive and grounded in data rather than on pre-existing theory (Langdridge 2007, 108). They are idiographic and primarily use purposive sampling in order to gather information about the experience from a specific group of people on a specific topic. Furthermore, these studies use semi-structured interviews with open-ended questions to

collect data designed to enable the participants to articulate detailed individual experience. For the analysis they mostly apply a thematic approach in order to identify major themes of the participant's life-world and, like discourse analysis, they are semantic, by focusing on language.

In this study, I created meaning and interpretation from analysis of the transcribed semi-structured interviews, which were designed for the collection of data on the experience of the outcome of psychotherapy. Since the aim of this study is to investigate the lived experiences of the learning outcomes of CBT and ET, the analysis of the data focused on recovering various phenomena in each individual set of data to generate a structural experiential description that encompasses all encountered phenomena.

This data analysis partly adopted Smith's model for IPA. That is, a six-stage thematic analysis which is used as the main analytical approach. However, this data analysis also introduced a seventh stage involving a comparison of the master themes from CBT and ET. Phenomenological research has previously been conducted as a comparative study in some cases. This has either involved utilizing research propositions for the relationship between different levels of themes, or predefined criteria of comparison (Dionisio 2008; Lopez 2004, 731). IPA has been conducted as a comparative study in one case (Dildar 2012). This has involved the development of contrasting themes.

The literature review in this study suggests that CBT and ET might be conceptualized in terms of educational objectives, and the comparison in this study will identify whether there is compliance for the learning outcomes with the educational objectives, and whether the difference between the learning outcomes is comparable to the difference between the educational objectives.

IPA admits that the analysis is always an account of how the analyst thinks the participants are thinking. Therefore, this project included a critical reflection on researcher positioning in order for the researcher to have a neutral position and bolster the impartiality of the descriptions of each form of therapy.

The seven stages of the thematic analysis are as follows:

Step 1. Reading and re-reading

The first stage involved immersing myself into the translated transcripts by reading and re-reading the data. Following Husserl, phenomenology is a holistic perspective and therefore it was crucial that I initially engaged with the whole transcript in depth (Husserl 2012). In this stage, my aim was to enter the participant's world by way of active engagement with the data in the form of listening to the audio recordings at least once while reading the translated transcript, in order to ensure that the participant became the focus of the analysis (Smith 2010, 82). Repeated reading permitted me to capture the meaning of the text and allowed the development of an overall model of the interview structure to emerge.

Step 2. Initial noting

Following Smith, the second stage involved examining semantic content and language use on an exploratory level (Smith 2010, 83). In this very time-consuming stage, my aim was to produce a comprehensive and detailed set of notes and comments on the data, and I wrote these notes and comments in the left margin of the transcript. My exploratory comments

focused on analyzing the content, language and concepts of the text. I focused on the participant's key words, phrases, explanations, presenting of meaning, and overarching understanding, which structure the participant's life-world. In this stage, I primarily had a clear phenomenological focus and I attempted to have a descriptive core in my commentary. Therefore, I made sure that my exploratory commenting stayed close to the participant's explicit meanings and the language and concepts they used. With each transcript, I repeated this stage three times in order to ensure that I captured the meaning of the text. There is a full example of this process in appendix 2. Below is an example from the transcript of Klara (I6):

Figure 2: Sample of transcript from interview 6 (I6):

[SECTION 1.2, A5-A10]	
A5: What did you hope to get from therapy	Hope to get deeper into oneself
K5: Yes, to get deeper um into myself and learn to know myself better.	Hope to learn to know oneself better
A6: Yes	
K6: Yes, see more, how can I look at opportunities instead of limitations, and, and, yes, the way I have chosen to live.	Hope to look at opportunities instead of limitations Hope to learn about the way one has chosen to live

A7: Yes K7: Yes [laughs] A8: Okay. In what ways did you think it would change your life? K8: I did not think about that at all. In what ways it would change my life. Because I did now know what was coming. I was curious about what happens. A9: What did you think that therapy could help you achieve? K9: Be myself and recognize myself. It was mostly that. A10: Yes, okay.	No expectations that it would change life because she did now know what would come from therapy Curiosity about therapy Expectation to be oneself Expectation to recognize oneself

Step 3. Developing emergent themes

Following Smith, the next step was to develop emergent themes (Smith 2010, 91). In this stage, my aim was to detect shifts in meaning in the protocols and divide it into pieces that seemed to express a sort of self-contained meaning from a psychological perspective. My focus shifted from working primarily with the transcript itself, to working with the

exploratory comments. However, I did this along with a continual cross reading of the transcript in order to make sure that I did not move away from the meaning expressed by the participant. This process represents a manifestation of the hermeneutic circle, where the original whole of the interview becomes a set of parts as the researcher conducts the analysis, and these then come together in another new whole at the end of the analysis in the write-up stage. As part of this, I now gave myself a more central role in organizing and interpreting the text. Therefore, the resulting themes do not only reflect the participant's original words but also my interpretation and inevitably draw on my own professional knowledge and experience. Following this process, I noted emerging themes in the right margin of the transcript. Thereby, I transformed the initial exploratory notes and comments into more meaningful statements, which reflected a broader level of meaning in a given section of the text. These themes are mostly phrases that express the psychological essence of the piece. Following Smith, in some cases, the titles of themes relate to concepts, which are evident within the psychological literature (Smith 2010, 92). In some places, I found it useful to deploy terms like "coping", "abilities", "experience", "capabilities", and "accept", "authenticity" in order to capture a conceptual understanding of the pieces. However, there was no theoretical use of these terms according to pre-existing psychological ideas. Furthermore, I only used psychological or existential terms that are just as much part of common language as of psychology. That is, I did not use any specific or technical psychological terms and I have made sure to avoid using any terms that refer to specific theoretical ideas. I will illustrate with a quote from Alma:

> *"And the man I was living with was miserable and seemed like he was almost chronically depressed, he was not good either. But. I. We could not reach each other.*

Um. So. But then I could see that uh I had some problems with my boundaries and I also wanted to have my own home, uh, and I when I told him, the situation got completely locked" (I1.B2)

From this piece of the transcript, I developed two emergent themes:

- Lack of ability to relate constructively
- Personal boundaries

Furthermore, I will illustrate with a longer sequence from Marta's transcript:

"A9: How did you experience starting therapy?

M9: Filled with anxiety. I was uncomfortable and very insecure and all the time I was in my head. Difficult to feel myself and to rest in myself, so in the beginning it felt stressful. However, quickly I found out that it what was actually good for me, and the way I was met made me able to relax…"

From this sequence of the transcript, I developed 10 emergent themes:

- *Anxiety*
- *Felt anxious at beginning*
- *Felt insecure at beginning*
- *Being in head in beginning*
- *Lack of ability to feel oneself*
- *Lack of ability to rest in oneself*
- *Stressful beginning*

- *Experience of therapy as doing good to self*
- *Therapy made able to relax*
- *Being met in therapy*

Following Smith, some of these theme titles may not be things, which the participants explicitly allude, to, but at the same time are closely connected to what they say (Smith 2010, 92). Thus, the theme titles relate directly to the content of the participants' discourse and I constantly attempted to make sure that I did not move away from the participants' expressions and meanings. I also did not come with a pre-existing set of categories or meanings that I imposed on to the data. In order to capture as much as possible of the meaning of each transcript, I tended to find as many emergent themes as possible. Once more, I will illustrate with a small sequence from Martha's transcript:

"A35: What about your ability to make choices, has there been a change in it?

M35: Well, today I say yes when I mean yes, and no when I mean no. I was much more able to feel what I want when I want it um and what I need and then do it".

From this little sequence, I developed six emergent themes:

- *More able to make choices*
- *More able to make genuine choices*
- *More able to say yes when meaning yes*
- *More able to say no when meaning no*
- *More able to feel what one want*
- *More able to act on own wishes*

Moreover, in several case, it seemed necessary to include terms like “initial” or “previous” in the titles of themes, in order to make clear that these were the participants’ experiences before they started therapy. I will illustrate this with a quote from Martha:

> *“When I started, I actually had some doubt about what I really should and what it was all about. I was probably in so little contact with myself that I did not dare to ask myself that question”. (I3.M6).*

From this piece of transcript, I developed two emergent themes:

- *Initial doubt about purpose of therapy*
- *Previously lack of contact with self*

In other cases, it was necessary to include terms like “changed”, “better” or “more” in the titles of themes, in order to make clear that these were the participants changed, transformed, improved or increased experiences from therapy. I will illustrate this with a sequence from the interview with Maria:

> *“A17: Did you during the course discover that your self-image changed?*
>
> *M17: Yes, a lot. There is a much greater affection to myself”.*

From this sequence, I developed two emergent themes:

- *Changed self-image*
- *More affection towards self*

With each transcript, I repeated this stage twice in order to ensure that I captured the

meaning. There is a full example of the process in appendix 2.

Step 4. Searching for connections across emergent themes

The next step involved developing a map of how I thought the themes fit. First, I typed all the themes, listing them in chronological order. Then, I choose to use Smith's method of abstraction for the ordering of connections between emergent themes (Smith 2010, 96). Therefore, I moved the themes around in order to identify patterns between emergent themes. I did this by putting like with like to form clusters of related themes and develop a new name for each cluster. Thus, super-ordinate themes emerged at a higher level. Again, my formulations of these super-ordinate themes were mostly phrases that expressed the psychological essence of the patterns. In most cases, the formulation of the super-ordinate theme reflected a combination of the participants varied expressions and my interpretation. In that way, I managed to produce a structure that allowed me to focus on the most important aspects of the participant's account. In order to ensure the richness of this focus I attempted to make many super-ordinate themes for each transcript. I will illustrate it with these emergent themes from Karen:

- *Self-image as vulnerable*
- *Self-image as composed person*
- *Self-image as weak*
- *Changed self-image in therapy*
- *Self-image changed due to diagnosis*

- *Anxiety attack changed self-image*
- *Quick experience of changed self-image*

From these emergent themes, I developed super-ordinate theme number 6 from Karen:

6. Changed self-image as more composed and vulnerable person

In some cases, I grouped super-ordinate themes entitled with terms like “previous” or “initial” together. I illustrate with these four emergent themes from Karen:

- *Previous lack of ability to accept own age behavior*
- *Previously lack of ability to feel young*
- *Previously afraid of being different*
- *Previously afraid of being abnormal*

From these emergent themes, I developed the second super-ordinate theme from Karen:

2. Previous lack of ability to accept oneself and fear of being different

Finally, I made a graphic representation of the structure of the emergent themes by creating a table of themes in which I annotated each super-ordinate theme with a number (See example in appendix 3). I also made a table of the super-ordinate themes that included an illustrative quotation from the transcript (See example in appendix 4). I will illustrate this with a sample from the table of super-ordinate themes with illustrative quotes from Anna (I7):

Figure 4: Sample of table of super-ordinate themes with illustrative quotes from I7:

Super-ordinate theme	**Quotation**
1. Previous self-image as impatient and control focused person	"Who had difficulties at being in the moment. This impatience" (N20)
2. Previously lack of ability to stand up for values and follow direction on life	"Then I just do not want to say anything and then get mad without doing anything about it" (N36)
3. Changed self-image as patient and present person	"I think that I am a person who can be in the moment and is less anxious for not making it all" (N25)
4. Better self-esteem and self-accept	"..my own self-esteem did get better" (N28)
5. More capable of standing up for existing values and follow own direction in life	"..I have become better to articulate them, when I feel, that there is something that goes against my values" (N35)

Step 5. Moving to the next case

The next stage involves moving to the next participant's transcript and repeating the process. I was focused on performing each individual analysis from scratch, and treating every case on its own terms.

Step 6. Looking for patterns across cases

The next stage involves looking for patterns across cases in each group of participants, CBT and ET (Smith 2010, 107). (A) As this process involves working with a large corpus of data, I chose to measure recurrence across cases. (B) Furthermore, as the answering of the research questions involves a comparison of the master themes in the two groups, I also decided that this stage should involve looking for a common structure in the two groups as part of identifying master-themes for each group.

6A) In step 6A, I made a decision that for a super-ordinate theme to be classified as recurrent, it must be present in at least half of the participant interviews for the particular group, CBT or ET. I made a table for establishing numerical recurrence in each group, which indicates whether the super-ordinate theme is present for each participant and then calculates whether the super-ordinate themes were present in half the cases. Since different participants may manifest the same super-ordinate theme in different terms and themes, this involved a negotiation of the relationship between convergence and divergence. Furthermore, it also involved a negotiation of the titles of the themes in order to find the essence of the different themes across cases. Sometimes this led to a reconfiguring and labelling of the themes:

6A.1) In some cases, several super-ordinate themes were subsumed under one recurrent theme with a new title. To give an example, super-ordinate theme number three from Alma, number seven from Maria, number seven from Martha and number 8 from Niels:

- *I1.3. Previous challenge of values and experience of disvalues*
- *I2.7. Previous challenge of values and attached value of marriage from upbringing*
- *I3.7. Previously unaware of having values in life*
- *I4.8. Previous complex set of values lack and of knowledge around wishes to self and life*

Labelled under the heading of the recurrent theme:

- *E1.5. Previous unawareness, complexity or challenges around values and wishes to life*

6A.2) Super-ordinate themes were in some cases subsumed under more than one recurrent theme. To give an example, the tenth super-ordinate theme from Niels:

- *I4.10. Changed self-image as insightful and conscious around self and life*

Is subsumed into two recurrent themes:

- *E1.10. More authenticity, self-consciousness, self-connectedness or ability to be oneself*
- *E1.11. Changed self-image*

6A.3) In some cases, there was a mixture. To give an example, super-ordinate theme 1 from Alma, theme 1 from Maria and theme 1 from Klara:

- *I1.1. Previous problematic self-image as guilty, weak and over responsible person being in the head*

- *I2.1. Previous problematic self-image with negative self-esteem around self-judging and self-criticism*

- *I6.1. Previous problematic self-image as less worth than others limiting everyday life*

All appear as parts of these two recurrent themes:

- *E1.1. Previous problematic self-image*

- *E1.4. Previous negative perception of self as weak, guilty, wrong or less worth*

In this way, I subsumed different super-ordinate themes across cases into new titles, which capture the essence of the different super-ordinate themes. This allows the development of an overall table of recurrent themes to emerge in each group.

6B) Step 6B involved using Smith's method of abstraction to move the recurrent themes around to identify patterns between them. This process involved putting like with like to form clusters of related recurrent themes and developing a new name for the cluster. Thus, master themes emerged at a higher level and produced a structure, which allowed me to focus on the most essential aspects of the participant's account. The choice of giving very long titles for each master-theme in order to capture as much as possible of the content weighed against giving short titles to master themes in order to capture more succinctly the most important essence of the theme. I choose long titles in order to provide a nuanced

foundation for the final comparison of master themes in the two groups. I formulated some of the master-themes in terms of learning in order to capture the learning outcome and learning process involved. Furthermore, my identification of master-themes in the two groups involved looking for a common structure in each table of master-themes. I made sure that this overall structure fitted each of the twelve tables of super-ordinate themes as well. This involved a reordering of the chronology in each table. The common structure that emerged was as follows:

1. Motivation for therapy
2. Learning outcome to do with self and life
3. Learning outcome to do with thinking, acting, feeling and coping
4. Learning outcome to do with relationships with others
5. Perception of therapy and therapist
6. Evaluation of learning outcome and learning process

Step 7. Comparison between groups

The final stage involves comparing the tables of master-themes in the two groups. For this purpose, I produced a table with the master themes put next to each other.

Chapter 4. Ethics

Research involving human participants requires the ethical approval of the relevant School Ethics Committee. The research is based on a successful research ethics application according to the ethics procedures at Middlesex University and the New School of Psychotherapy and Counselling (NSPC). The application was approved after minor corrections. The conditions for the approval was that I needed to sign the forms, state that I would provide English translations of the original transcripts and include details of safety precautions for lone interviews. No participant's research took take place until ethical approval had been gained.

The Ethics Committee at NSPC approved the research related to the following section:

The research was in accordance with the British Psychological Society's code of ethics and conduct, including their ethical principles of respect, integrity, competence and responsibility. I list some of the key ethical issues to research raised by Langdridge in the section below (Langdridge 2007, 62). Furthermore, I describe how I addressed them in this study.

4.1. Consent

In this study, I provided participants with full knowledge of the nature of the research through the information sheet. I gave them this sheet as part of the process of securing their agreement to participate. This was be supported by the consent form and any question was answered to ensure informed consent. I employed no deception in this study and participants retained the right to withdraw their consent at any stage of the research process.

4.2. Confidentiality

Confidentiality was specifically considered. In this study, all information gathered from the participants remained confidential. Therefore, I made data as anonymous as necessary in submitting the final project. Ethical considerations were strictly adhered to as participants' names were changed to protect their identity. I have kept transcripts securely and recordings were destroyed on completion of the project. The information sheet explained to the participants what would happen with the digital recordings of the interviews and the transcripts. Participants were informed that they had the right to expect to be treated with confidentiality and, if published, the data would not be identifiable as theirs.

4.3. Discomfort and harm

In this study, the researcher took responsibility to protect the participants from physical and mental harm. Thus, specific considerations were given to eliminate potential risk to psychological wellbeing, physical health as well as autonomy and dignity. Investigating personal experiences of therapy may be considered a sensitive issue, especially given the emotional experience of this activity. To ensure

this protection, I sent the participants the questions that were to be asked, which made them more able to choose to participate or not. At the end of the interview, the participants were also debriefed and I provided contact details for the researcher following the interview. It was my responsibility to protect participants from mental harm. To support this I:

1. Sought ethical approval for this project and adhered to any feedback in the process
2. Sent the information sheet in advance
3. Sent the interview questions in advance
4. Reminded participants that they were free to choose to terminate the interview at any time and, in doing so, their contributions would be destroyed and not used in the analysis.
5. Emphatically checked-in with the participants if it becomes clear that the material became emotionally demanding. For this, I used my therapeutic skills, and if necessary provided them with details of support services
6. Debriefed participants at the end of the interview and provided my contact details following the interview.

4.4. Precautions by proofreading

In this study, I personally performed all transcription and translation of the interviews. A professional proofreader revised the thesis before submission. However, the professional proofreader did neither read, revise or edit the original transcripts. This ethical precaution secured

that information gathered from the participants remained confidential. The precaution also secured that no one edited or changed the original data-material.

Chapter 5. Presentation of results

In this chapter, I will present the results of my analysis. I will focus on presenting the master themes in three sections according to this common structure:

1. Motivation for therapy
2. Life learning outcome
3. Thinking, acting, and feeling learning outcome
4. Relationships with others learning outcome
5. Perception of therapy and therapist
6. Evaluation of learning outcome and process

Firstly, I will present the master themes from the group of participants that were in ET:

Figure 5: Table of existential therapy (ET) master themes

E1	Varied motivation for therapy based on mental discomfort or wish for self-knowledge. Hope for well-being, self-exploration or authenticity. Expectation of capabilities and insight for self and life.
E2	Learning authentic, valuing and caring relation to oneself with changed self-image and more insight into self and life. Engagement, satisfaction and sense of direction and values

	with an open and courageous approach to life and participation in the world, as opposed to previous partially problematic self-relation and self-image with lack of abilities for sensing and following values and direction in life.
E3	Learning capabilities for coping with difficulties. Making genuine choices, calm way of reacting, open way of thinking. Acting from own position in life and taking own responsibility, in contrast to previous lack of capabilities to cope with difficulties and feelings. Taking responsibility and making choices.
E4	Learning capabilities for engaging in mutual relationships as oneself, with abilities to set limits and respect others. This compared to previous problematic way of relating, with a lack of capabilities for constructive engagement as oneself in mutual relationships.
E5	Therapy as a meeting space for in-depth exploration, questioning, transformation and becoming of self. Learning for a life of courage and freedom following client's agenda. Relationship to therapist as assistant revelator and companion being with and for client.
E6	Positive therapeutic relationship and choice of approach as important for intense and demanding learning process and positive learning outcome.

Secondly, I will present the table of master themes from the group of participants that were in CBT:

Figure 6: Table of CBT master themes:

C1	High motivation for therapy reflecting in choice of therapist based on depression, anxiety and stress or emotional burden. This related to wider life problems with hope for outcome as fixing or improvement of mental state. Expectation of learning of tools for coping.
C2	Learning capabilities for capable, caring and valuing self-relation, with more positive self-image and better self-esteem. Following own values and direction in life with an open approach to life and participation in the world. In contrast with previous negative self-relation and self-image with lack of abilities for sensing and following values and direction in life.
C3	Learning capabilities for organizing thoughts, coping with difficulties, and handling responsibility and choices, with appropriate and reflected way of acting and thinking, and a relaxed way of reacting. As opposed to a previous lack of abilities for coping with difficulties and a problematic way of thinking and acting.
C4	Learning capabilities for being oneself as an independent person, and engaging in self-chosen mutual relationships with abilities for accepting, coping with criticism, and setting limits. Compared to previous problematic way of relating and lack of ability to be oneself in relationships.
C5	Therapy as an educational framework for learning opening of perspectives and focusing on positive self-awareness through tools for coping with thoughts, feelings and actions. This based on specific therapeutic techniques and questioning, utilizing the relationship with the therapist as guiding teacher and friendly partner for sparring.

C6	Importance of good therapeutic relationship, personality of therapist and effective therapeutic approach for the learning process and a positive outcome of therapy with minor disappointments.

Thirdly, I will present the comparison of the two tables of master-themes.

5.1. Existential therapy (ET)

In this section, I will present my findings on ET by focusing on the tables of the six master-themes.

In appendix 8-13, I present the each master theme along with a secondary table of the subsumption of recurrent super-ordinate themes for this particular master theme. The secondary table shows whether the recurrent super-ordinate theme is present for each participant.

5.1.1. Existential therapy master theme 1 (E1): Motivation

The first master theme concern the motivation for going into therapy in the group of participants from ET in their own looking back (Appendix 8):

Master theme E1

Varied motivation for therapy based on mental discomfort or wish for self-knowledge. Hope for well-being, self-exploration or authenticity. Expectation of capabilities and insight for self and life.

A. Motivation and decision

The findings of four recurrent themes concern the participants' decision and psychological motivation for starting therapy (E1.1, E1.3-6). All participants articulate experiencing a motivation for therapy although to one of the participants the motivation mostly comes from actually being in therapy.

A.1. Motivation for therapy

The findings show the participants psychological motivation for therapy. All participants either articulate a high, modest or increasing motivation for therapy (E1.1).

Alma and Niels articulate having had an initial high motivation for therapy (I1.B3, I1.B12, I4.N1, and I4.N6). Karen and Klara more moderately indicate an initial motivation for therapy (I5.K7, I6.K11).

Maria and Martha both articulate the experience of an increasing motivation for therapy (I2.M8, I3.M10). Martha articulates a certain doubt about going into therapy. However, her motivation increased as she began to feel a change from being in therapy (I3.M8, I3.M10).

A.2. Decision making

The findings of three recurrent themes (E1.4-6) show the participants either have decided to go into therapy based on an experience of poor well-being or a mental problem or from a wish for self-knowledge.

Alma, Martha and Karen describes how their decision to go into therapy related to the experience of mental problems of anxiety, stress or phobia (E1.4). Alma:

> *"I have always had, uh, as long as I can remember...ten years or something like that, eight or ten years. A very strong phobia of falling, we usually call it fear of heights..." (I1.B21).*

Alma uses the term "phobia" four times and the term "anxiety" twice to describe her previous mental problem. Martha uses the words "anxiety" and "stress" once each to describe her mental state as she started therapy, and uses the word "stress" four times to describe the mental problem which made her decide to go into therapy (e.g. I3.M1). Karen uses the term "anxiety" eight times to describe her problem, and she uses the term "disease" once to articulate her problem (e.g. I5.K1-2).

Thus, half of the participants articulate a concrete mental problem as part of the background for their decision to go into therapy. At least two of these participants, Karen and Alma, tend to use the terms "anxiety" or "phobia" in accordance with their clinical meaning. However, only Karen uses the term "disease," and the findings do not involve the suggestion of an overall adoption of psychiatric diagnostics from being in ET. Furthermore, only Karen explicitly seems to articulate learning the terms "anxiety" and "anxiety attack" from therapy. Thus, Karen describes how she was not able to

articulate her experience as an “anxiety attack” before she went into therapy (I5.K1). The findings from Alma suggest that she used clinical terms to describe her problem prior to starting therapy as she articulates having had "phobia" for many years.

Alma, Maria and Karen describes their decision of therapy as based on a lack of well-being or an experience of self-problems (E1.5). Whereas Alma and Karen explicitly describe a state of lack of well-being as the reason for going into therapy (I1.B3, I5.K7), Maria describes her decision in slightly other terms: *“I felt it was difficult to get over the edge. Something stopped me somehow”* (I2.M1). Thus, Maria articulates an experience of self-problems.

Maria, Niels and Klara describe the decision to go into therapy as based on a wish for self-knowledge, self-development or self-insight (E1.6). Maria's wish for self-knowledge clearly seems related to her experience of self-problems (I2.M1). Niels and Klara do not articulate an experience of self-problems as the reason for their wish for self-knowledge or self-insight. Niels:

> *“In that sense, my choice was not based on anguish [..] It was more about self-development and about exploring the possibilities of how the world could also look, and life could also be seen, and I could see myself through therapy” (I4.N1).*

Almost like Klara (I6.K5), Niels explicitly states that his decision was not based on a lack of well-being or a mental problem but rather on a wish for self-insight and self-development. However, the transcripts show that both Niels and Klara previously have been experiencing existential or mental challenges. Yet, they do not articulate this experience as the main background for their decision to go into therapy.

B. Wishes and expectations for therapy

The findings of three recurrent themes indicate the participants' initial hopes, wishes and expectations for the process and outcome of therapy (E1.2, E1.7, and E1.8):

B.1. Hope or wish for development or improvement of self or life

Alma, Maria, Niels and Klara articulate the experience of having had an initial wish for an outcome of authenticity, being oneself or existential learning about oneself as part of their motivation for beginning therapy (E1.2). Alma:

> *"To get peace of mind, not spending all nights turning around in bed and being in my head, that I would be able to get some rest. As some kind of hope, I just hoped" (I1.B9)*

Alma articulates a strong initial wish for the outcome of therapy as happiness and a possibility to be herself, as related to an experience of previous anxiety and lack of well-being (I1.B3, I1.B9, and I1.B21). Maria articulates a wish to become authentic and steady, related to an initial experience of personal barriers and lack of ability to realize herself (I2.M1, I2.M6). As we have already seen, Niels articulates a strong wish to learn in-depth knowledge about himself (I4.N1). Klara likewise articulates an initial wish to learn in-depth knowledge about herself (I6.K5).

B.2. Hope or wish for exploration of self

In the learning process of therapy, Maria, Niels and Klara articulate an initial wish for an in-depth exploration or uncovering of themselves (E1.7). Maria hopes for an in-depth exploration of her personal barriers related to her initial experience of self-problems and her wish to become authentic (I2.M1, I2.M5). For Niels and Klara, the wish for an in-depth exploration of themselves relates closely to their wish for a learning outcome of deep knowledge about themselves (I4.N1, I6.K5). However, Niels also describes how his wishes for therapy changed during the course, related to the appearance of certain life challenges (I1.N8).

B.3. Hope or wish for improvement of mental state

Alma, Martha and Karen articulate an initial hope or wish for happiness, well-being or removal of anxiety (E1.8). Karen explicitly articulates her initial experience as a hope for removal of anxiety symptoms (I6.K5). Martha describes how she experienced a gradual appearance of a hope of feeling better (I3.M1, I3.M10). Alma articulates the experience of an initial hope for more well-being and happiness (I1.B3, I1.B7, I1.B9, and I1.B15).

B.4. Expectation of insight and capabilities for self and life

Alma, Maria, Martha and Klara articulate an initial or gradual expectation of a positive outcome of therapy as insight into or abilities to handle the self or life or becoming the self, closely related to their hopes for well-being or authenticity and the initial experiences of a lack of well-being or wish

for self-knowledge (E1.3). Maria articulates an expectation of a learning outcome of an insight into her whole self, related to her initial experience of self-barriers and a wish for authenticity through deep self-exploration (I2.M1, I2.M5-M6). Alma articulates an expectation of an outcome of capabilities for relating and handling life, related to her experience of lack of well-being and wish for happiness (I1.B3-4, I1.B7, I1.B9, I1.B15, and I1.B21). Martha articulates the expectation of a positive outcome of self-care and self-abilities with a wish for more well-being related to her experience of stress and lack of well-being (I3.M1, I3.M7, and I3.M10). Klara articulates the expectation of an outcome of becoming and recognizing herself related to her wish to learn in-depth knowledge about herself (I6.K5, I6.K9).

5.1.2. Existential therapy master theme 2 (E2): Self and life

Overall, this finding shows that the participants experienced a learning outcome to do with self and life from their previous experiences of self and life (Appendix 9):

Master theme E2

Learning authentic, valuing and caring relation to oneself with changed self-image and more insight into self and life. Engagement, satisfaction and sense of direction and values with an open and courageous approach to life and participation in the world, as opposed to previous partially problematic self-relation and self-image with lack of abilities for sensing and following values and direction in life.

A. Previous experiences

The findings of nine recurrent themes (E2.1-9) show which initial experiences the participants from ET had regarding their self and their life in their own reflection:

A.1. Previous problematic self-relation

These findings from four recurrent themes (E1.1-2, E2.4, and E2.8) indicate that most participants from ET previously experienced a problematic self-relation.

The table indicates which challenges the participants had about their self. Thus, the table indicates a recurrent experience of problematic self-image amongst five of the participants (E2.1). Alma:

> *"I was a person who always had to make great efforts in relation to others, in relation to everything, to make me deserve to be allowed to be here" (I1.B15)*

Alma articulates seeing herself as a person with many problems who was full of guilt, weak and living in her head. Likewise, Maria has a critical and self-judging image of herself (I2.M14) and Klara has an image of herself as a person who was worth less than others (I6.K15). Martha retrospectively articulates a previous self-image of a comfort-seeking and conflict-avoiding person (I3.M11), and Niels perceives himself as having had a problematic self-image as a person who was pleasing others (I4.N11).

To four participants, this experience seems related to experiences of lack of self-connectedness and self-care (E2.2). Martha articulates a previous experience of not being in contact with herself and lacking the ability for self-care from lack of self-insight (I3.M4). Likewise, Alma articulates a previous

experience of lacking personal boundaries (I1.B4); Niels of lacking ability to feel self and personal limits (I4.N11); and Klara of concealing parts of herself (I4.K4).

Those four participants also articulate the lived experience of negative perceptions of self (E2.4). Like Niels who articulates the downside of his previous strategies for coping as a feeling of being wrong and not being an adult (I4.N21). Likewise, Alma saw herself as weak and guilty (I1.B15), and Maria and Klara saw themselves as having a low worth (I2.M14, I6.K15).

Three of these participants, Maria, Karen and Klara, also articulate a previous devaluation of their self or their actions (E2.8). Klara: *"I had this thing that I devalue myself all the time (I6.K15)".* Klara articulates a previous experience of feeling less worth and devaluing her own actions and appearance.

A.2. Previous resourceful self-relation

Maria, Martha, Niels and Karen articulate having a resourceful self-image to begin with (E2.3). Karen: *"... it is a resource to have me in the group because there is nothing that can bring me down" (I5.K12)*

In addition, Martha: *"... there were many people who liked me. That I was a good friend and they could call me" (I3.M15).* However, on reflection, Martha describes this self-image as fake. She kept it up because she thought it would benefit her.

To three of the participants, Maria, Niels and Karen, this self-image relates to a valuing of their self to do with their career, intelligence, or social or professional skills (E2.9). For some participants, Maria, Martha and Niels, the experience of a resourceful self-image involves the indication of a positive perception of their professional or social performance combined with negative self-esteem or problematic valuation of self (e.g. I2.M16, I4.N10, I4.N11, I3.M15, and I3.M21).

A.3. Previous issues to do with values and direction in life

The findings of two recurrent themes (E2.5, E2.7) indicate varied experiences of previous issues to do with values and direction in life.

Four participants express an initial experience of problems to do with values and wishes for life (E2.5). Martha: *"I did not know that I had values before" (I3.M27).* Martha describes how she previously did not realize that she had values, because she did not know herself. Alma and Maria

articulate a previous challenge of values and experience of disvalues or attached values (I1.B24, I2M27). Niels articulates having had a complex set of values (I4.N20).

Alma, Maria and Martha, also articulate a lack of sense of control or direction in life (E2.6). Like Alma:

> *"Before I did not at all experience that I could decide a direction and decide that I wanted to follow it" (I1.B24)*

Previously Alma did not experience that she was the one who decided the direction of her life and she felt it was too risky attempting to decide one.

The other three participants, Niels, Karen and Klara, articulate having an initial goal-, control- or self-centered attitude to their lives (E2.7). Like Karen:

> *"To believe that you are the center of the world and believe that you are the focal point for all" (I5.K22)*

Karen articulates previously having a direction getting though life with herself as the center of the world. Niels articulates an experience of having had a precise direction in life since the age of 15 (I4.N18).

B. Learning outcome to do with self and life

The findings of thirteen recurrent themes (E2.10-12) indicate the experienced learning outcome of ET regarding the participants self and life:

B.1. Learning an authentic and caring relation to oneself

The findings of two recurrent themes (E2.10, E2.12) point to the major learning outcome of learning an authentic and caring relation to oneself. This is especially because most of the participants articulate a previous experience of a problematic self-relation or a lack of self-care or self-connectedness.

The findings show that one learning outcome amongst all the participants is a development of more authenticity, self-consciousness, self-connectedness or ability to be oneself (E2.10). Alma: *"I am more able to be in myself" (I1.B39)* and *"I dare being myself, I dare and I can" (I1.B40).*

Alma articulates an experience of this learning outcome as becoming herself as an independent person with a right to exist and a value of being happy. Likewise, Maria articulates an outcome of authenticity (I2.M20); Martha of self-connectedness and self-insight (I3.M35); Niels of self-consciousness and self–insight (I4.N15); Karen of finding and being herself (I5.K21); and Klara of the ability to be in the world and show herself (I6.K52).

Furthermore, these findings show that all participants experience the learning outcome of being more affectionate, loving or accepting in relation to themselves and their lives (E2.12). Klara describes how she previously devalued herself, and used to explain and apologize for herself, but

has now learned to accept herself and stand by herself (I6.K22). Likewise, Alma articulates learning to valuate her own right to exist and be happy (I1.B40).

B.2. Learning outcome of changed self-image

The findings show that all participants articulate the lived experience of the learning outcome of a changed self-image (E2.11). This is important, because most of the participants articulate a previous experience of a problematic self-image or a negative perception of themselves. Alma: *"A person who is filled with a great desire for life, a desire and an expression of living [...] trust and confidence in the outside world and to fate" (I1.B17)*

Whereas Alma previously saw herself as a weak person with many problems, she articulates the lived experience of the learning outcome of a more positive self-image as a more engaged and courageous person.

B.3. Learning a better sense of values and valuing the relation to oneself

The findings show that all participants experience the learning outcome of a better sense of values or ability to stand by their own values (E2.13). Like Niels:

"..I am very conscious about my values to the bone" (I4.N19)

Whereas Niels previously experienced his values as complex, he articulates a learning outcome of having three very clear life values. Likewise, Martha, Alma and Maria articulate previous experiences

of unawareness or challenge of values, but also the experience of the learning outcome of getting a better sense of their values or a better ability to stand by their values (I1.B27, I2.M30, and I3.M27). Karen describes how she has become more aware of her values (I5.K34), and Klara articulates an increased valuing of life and herself (I6.K21-2).

Furthermore, the findings show that five participants experience more valuing of care, engagement, happiness or being themselves (E2.16). This is particularly because several participants previously experienced problems to do with values and wishes of life or were devaluing themselves. Karen articulates how she has increased her focus on what makes her happy in life (II5.K22). Likewise, Alma describes the learning outcome of a right to exist and value being happy (I1.B39-40); Maria of valuing her own health and well-being (I1.M45); Martha of more groundedness and joyfulness in life (I3.M17); and Niels of engaging and being present in life (I4.K32).

B.4. Learning engagement and satisfaction

Alma, Maria, Martha, Niels and Klara experience the outcome of a more capable, satisfied, joyful, engaged, insightful or open self (E2.14). Niels: *"I see myself as someone who has a greater insight into um everything" (I4.N15).* Niels articulates a learning outcome of more self-insight and more insight into life.

These five participants also experience the outcome of more creativity, engagement, courage, satisfaction, well-being or energy in life (E2.15). Like Alma:

> *"Where I could just be happy about living as a natural thing and feel okay about being myself, and just wish for my own happiness, and that I didn't have to perform all the time" (I1.B19)*

Whereas Alma previously saw herself as a person who had to make an effort in relation to everything to deserve to exist, she articulates the lived experience of the learning outcome of a more satisfied and energetic life.

B.5. Learning an open and courageous approach to life

The findings of two recurrent themes (E2.17, E2.21) show that most participants express learning a more open or courageous approach to life as well as the ability to endure life.

Alma, Maria, Martha, Niels and Karen experience the outcome of a more open, reflected, meaningful, inward, courageous or patient approach to life (E2.17). Like Martha; *"I do not know what will happen now and that is great" (I3.M26).* Martha used to feel that she was living in a prison but articulates the experience of learning a freer and more open approach to life.

Furthermore, Maria, Niels and Klara, articulate more insight into the ability to endure life (E2.21). Maria: *"There is a greater calm um more confident about myself" (I2.M17).* Maria articulates the experience of learning to endure fluctuations in life.

B.6. Learning a sense of direction in life

The findings of two recurrent themes (E2.18, E2.22) indicate the outcome of more sense of direction in life or positioning in life.

Alma, Maria, Martha and Niels articulate the lived experience of more sense of direction in life or ability to prioritize their own wishes or goals in life (E2.18). Maria: *"I can say it is, this is what I want and this is what I want to live according to" (I3.M26).* Whereas Maria previously had a diffuse sense of direction in life and lacked the ability to realize her goals, she articulates the learning outcome of being more able to reach her goals and give her life a clear direction.

Alma, Maria and Martha articulate developing more sense of control or positioning in life (E2.22). Like Alma: *"... now I can decide a direction" (I1.B24)*. Whereas Alma previously lacked a sense of control over her own life and had the feeling that she did not decide her direction in life, she articulates the learning outcome of having more sense and control of her direction in life with the prioritizing of her wishes and desires (I1.B18).

B.7. Learning to accept anxiety and to live with freedom

Martha, Niels, Karen and Klara articulate the lived experience of becoming more able to accept uncertainty, anxiety or crisis and to live with freedom (E2.19). Like Niels:

> *"I probably also see myself as very conscious about the existential conditions and about the freedom to choose and the uncertainty in this" (I4.N15)*

Whereas Niels was previously overwhelmed by his feelings and attempted to control things, he articulates the learning outcome of being conscious about his freedom to choose and the freedom involved.

B.8. Learning engaged participation in hobbies and communities

Maria, Martha, Niels and Klara articulate the lived experience of developing a more desiring, engaged or chosen participation in communities or hobbies (E2.20). Like Klara, who articulates the learning outcome of having a new desire for art and nature and having changed her wishes to do with friendships (I6.K54).

5.1.3. Existential therapy master theme 3 (E3): Thinking, acting and feeling

Overall, this finding indicates the participants' experienced learning outcome to do with their thinking, acting, feeling and coping with their previous experiences (Appendix 10):

Master theme E3

Learning capabilities for coping with difficulties. Making genuine choices, a calm way of reacting, and an open way of thinking. Acting from own position in life and taking own responsibility, in contrast to previous lack of capabilities to cope with difficulties and feelings. Taking responsibility and making choices.

A. Previous experiences

The findings of four recurrent themes (E3.1-4) show which initial lived experiences the participants from ET had to do with their thinking, acting, feeling and coping with their own recollections:

A.1. Previous lack of constructive abilities to do with difficulties

The findings of two recurrent themes (E3.1, E3.2) indicate an experience of previously lacking abilities for constructive relating to and coping with difficulties.

Five participants articulate an experience of previously lacking abilities for coping with difficulties constructively (E3.1). Martha: *"Something about getting out of it, it was difficult, get back to comfort and safety" (I3.M31).* Martha describes how she previously lacked the abilities to stay and cope with difficulties.

These five participants, everyone except from Karen, also articulate an experience of previous over-emotionality, over-thinking or over-reacting to do with difficulties (E3.2). Niels: *"I um was very emotionally affected. Very emotionally affected. That is, if I experienced something, which stressed me. Then I stressed very much" (I4.N21)* Niels describes how he used to be over-emotional around difficult situations, and furthermore, he lacked the abilities for constructive coping. Either he turned to a friend or turned to his career (I4.N11, I4.N21).

A.2. Previous lack of abilities to take responsibility and make choices

Alma, Maria, Karen and Klara articulate a lived experience of previously lacking abilities for being responsible and to make choices (E3.3). , Klara: "*It was a little heavy to have responsibility*" (I6.K41). Klara describes how she used to feel it heavy to have responsibility, because it involved a feeling of pressure.

A.3. Previous lack of ability to understand or cope with feelings and anxiety

Alma, Martha and Karen articulate a lived experience of previously lacking the ability to understand, accept or cope with feelings or problems of anxiety (E3.4). Like Karen; *"I have just always suppressed it. Was come over it, and moved on" (I5.K11).* Karen describes how she experienced an anxiety attack without knowing what it was (I4.K1). She also describes how she previously always had these experiences of anxiety but used to handle them by suppressing her anxiety (I4.K11).

B. Learning outcome to do with thinking, acting and feeling

The findings of six recurrent themes (E3.5-E3.10) indicate the experienced learning outcome of therapy to do with the participants' thinking, acting and feeling. The show that most participants learned capabilities for coping with difficulties, making choices, reacting in a calm way, an open way of thinking and acting and taking responsibility, as related to previous difficulties within this area.

B.1. Learning capabilities for coping with difficulties

All participants articulate a lived experience of becoming more capable of a relaxed, serene, reflected, present, containing or accepting way of coping with difficulties (E3.5). Alma: *"When it really starts to get serious, then it is much easier" (I1.B37)*. Alma articulates a lived experience of having learned a relaxed way of coping (I1.B2, I1.B37).

B.2. Learning abilities to make genuine choices

Five participants articulate a lived experience of becoming more capable of making genuine choices (E3.6). Karen: *"...I have become more aware that it is okay to make these choices"* (I5.K33). Whereas Karen used to find it difficult to accept her own choices, she articulates a lived experience of becoming aware that they are acceptable (I5.K33).

B.3. Learning a calm way of reacting

Alma, Maria, Karen and Klara articulate the experience of having developed a calmer, reflected, relaxed or caring way of reacting (E3.7). Maria: *"I think that I am far more reflecting and courageous"* (I2.M39). Whereas Maria previously reacted to difficulties by losing her temper or keeping to herself, she articulates an experience of learning a more courageous and reflected way of reacting to difficulties (I2.M39, I2.M40).

B.4. Learning capabilities from acting from own position in life

Four participants articulate the experience of becoming more capable of acting within their own limits, values, awareness or maturity (E3.8). Martha:

> *"It is something completely conscious to say things loud um, if I disagree with something, or if there is something that I do not want to take part in" (I3.M18)*

Whereas Martha articulates the experience of previously pleasing others, she learned to set limits and act from her own position in life (I3.M15, I3.M18). Likewise, Maria, Niels and Klara articulate similar experiences in varied ways.

B.5. Learning a more open way of thinking

Martha, Niels, Karen and Klara articulate learning a more open, solution focused or self-confident way of thinking (E3.9). Karen: *"Not everything is as important as I made it. In that way, I started to think differently"* (I5.K16). Whereas Karen previously experienced controlling thinking around a need of a full view, she articulates the experience of learning a less controlling way of thinking with less need of a full view (I5.K15, I5.K16).

B.6. Learning the ability to take responsibility

Maria, Martha, Niels and Klara articulate becoming more able to identify or take responsibility (E3.10). Especially, because many participants articulated a previous experience of a problems to do

with taking responsibility. Niels: *"... to take responsibility for um that um that when I meet situations, which I find hard to handle, then um I do something about it" (I4.N29)* Niels articulates an experience of becoming more capable of taking responsibility for difficult situations.

5.1.4. Existential therapy master theme 4 (E4): Relationships with others

The fourth master theme concerns learning outcome of ET to do with relationships with others (Appendix 11):

Master theme E4

Learning capabilities for engaging in mutual relationships as oneself, with abilities to set limits and respect others. This compared to previous problematic way of relating, with a lack of capabilities for constructive engagement as oneself in mutual relationships.

A. Previous experiences

The findings of three recurrent themes (E4.1-E4.3) show the initial lived experiences the participants from ET had regarding their relationships with others:

A.1. Previous problematic relatedness and tendency to other-focus in relationships

Five participants articulate the experience of a previous tendency to suspicion, pleasing, avoidance, criticism or dependence on others (E4.1). Alma describes how previously she constantly had to fight or perform in relation to others in order to get respect and deserve to exist (I1.B15). Niels describes how he used to please everyone in order to uphold an image of himself as a good person (I4.N22, I4.N11). Likewise, Martha describes how she previously engaged in relationships in order to be liked (I3.M15); Karen was unaccepting and critical of others (I5.K11); and Klara was suspicious of others and preoccupied with their thoughts about her (I6.K47).

A.2. Previous lack of ability to be oneself and engage in mutual relationships

The findings of two recurrent themes (E4.2, E4.3) indicate an experience of previously lacking the ability to be oneself and/or engage in mutual relationships.

Alma, Martha, Niels and Karen articulate a previous lack of ability to engage in mutual or giving relationships (E4.2). Martha: *"That I was a good friend and they could call me [...] That I used to think that I would get something out of it" (I3.M15)* Martha describes how she previously had a tendency to engage in unilateral relationships in order to be liked. In a different manner, Niels describes how he used to have difficulty engaging in direct relationships with other human beings and used to experience his work relationships in an object-like manner (I4.N22).

B. Learning outcome to do with relationship with others

Niels, Karen and Klara articulate a previous lack of ability to be, articulate or stand by oneself in relationships (E4.3). Klara describes how she previously experienced a lack of ability to articulate and show herself in relation to others, because she was preoccupied with their thoughts (I6.K52).

Secondly, the findings of three recurrent themes (E4.4-6) indicate the experienced learning outcome of therapy regarding the participants' relationships with others:

B.1. Learning capabilities for engaging in mutual relationships

All participants articulate learning to engage in mutual, giving, joyful, constructive or open relationships (E4.4). This is important, because most participants articulate an experience of previously lacking these capabilities. Like Martha; *"..., today relations to me is that we must be connected, we must have something together" (I3.M39).* Whereas Martha used to engage in unilateral relationships, she describes how she has learned that there must be connection and mutuality in relationships (I3.M15, I3.M39).

B.2. Learning capabilities to be oneself in relationships

Alma, Maria, Martha Karen and Niels articulate becoming more able to be themselves in relationships (E4.5). This ability seems important as most participants articulate a previous experience of being unable to. Niels: "*I have a feeling of being able to be myself at all times, in all ways, and then still be loved*" (I4.N22). Whereas Niels articulated previous experience of a lack of

the ability to be himself and engage in direct and mutual relationships with other human beings, always pleasing others, he experienced becoming more able to be himself in relationships without having to please others (I4.N22).

B.3. Learning capabilities to set limits and to respect others in relationships

Niels, Karen and Klara articulate becoming able to communicate, set limits, take confrontations, respect or accept in relationships (E4.6). Like Karen: "*Then you are able to put yourself in other people's crisis" (I5.K19).* Karen used to find it difficult to accept other people's weaknesses (I5.K11). However, by learning to accept her own vulnerability she has also learned to be more open to other people's weaknesses and become compassionately caring for others (I5.K19).

5.1.5. Existential therapy master theme 5 (E5): Therapy and therapist

The finding indicates how the group of participants from ET perceived therapy and the therapist as a frame and process for the learning (Appendix 12):

Master theme E5

Therapy as meeting space for in-depth exploration, questioning, transformation and becoming of self and learning for life of courage and freedom following clients agenda with relationship to therapist as assistant and recognizing revelator and companion being with the client

A. Therapy

The findings of seven recurrent themes indicate the participants overall lived experience of therapy (E5.1, E5.3, 5.4-6, E5.11-12):

A.1. Therapy as learning to do with self

These findings of three recurrent themes (E5.1, E5.3, and E5.11) show how the participants perceived therapy as an in-depth learning to do with their selves, involving a transformation of their selves.

All participants articulate a lived experience of therapy as authentic or in-depth learning, to find, be or accept themselves (E5.1). Martha: *"I started to ask questions to who I was, and what I really contained, what kind of strengths I have, what my resources are" (I3.M16).* Thus, Martha perceives therapy as learning to be a genuine self through questioning herself. Likewise, Niels articulates a lived experience of therapy as an exploration and testing of himself (I4.N13). These findings fit with the finding of learning authenticity, self-consciousness, self-connectedness or the ability to be oneself as a major experienced learning outcome (E2.10).

Alma, Maria, Martha, Niels and Klara articulate therapy as a space for caring for, unfolding of, accepting or being oneself (E5.3). Alma: *"So this was a place that was just for me to use, and it was lovely, really nice, I needed that"* (I1.B13). These findings especially fit with the finding of learning a more loving, caring or affectionate relation to oneself as a major experienced learning outcome (E2.10).

Alma, Maria and Klara articulate a lived experience of therapy as in-depth or long-term change, transformation or transgression of their whole being or self (E5.11). Alma: *"...if you start to feel your own feelings, you automatically do some other things, because you find yourself somewhere else than you were before" (I1.B19)* and *"The boundaries are falling apart" (I1.B42).* Thus, Alma articulates a lived experience of therapy as a transformation of herself and her boundaries.

A.2. Therapy as learning to do with life

The findings of three recurrent themes (E5.5-6, E5.12) show how the participants perceived therapy as learning to do with life and living with acceptance of the uncertainty in freedom. These findings are important because many participants decided to go into therapy based on an experience of problems in their lives or a lack of well-being in living, and articulated an expectation of learning capabilities for life.

Maria, Alma, Martha and Niels articulate a lived experience of therapy as a learning for life (E5.5). Maria: *"Look at my past, what it can bring and what I must choose"* (I2.M50). Maria articulates a lived experience of therapy as learning a more creative and courageous stand on life, and new ways of looking at life. This finding especially fits with the findings from E2 of learning to do with life as a major experienced learning outcome.

Five participants articulate a lived experience of therapy as learning creativity, courage or valuing life (E5.6). Karen: *"...It is like trying to find into, that I am just myself, and I am a human being"* (I5.K21). Karen articulates a lived experience of therapy as learning to value life and living (I5.K21-

22). Likewise, Maria, Martha, Niels and Klara articulate similar experiences of therapy in varied forms.

Martha, Niels and Klara articulate a lived experience of therapy as learning to enter or accept uncertainty and freedom (E5.12). Martha; *"...I do not know what will happen now and that is great. However, it has also been filled with anxiety to get there" (I3.M26)*. Martha articulates a lived experience of therapy as a difficult learning process accepting the uncertainty of freedom and describes how this process has been anxious for her. Martha is an example of someone who has a recurrent perception of therapy as a learning to enter, stay in and accept the uncertainty of life, which is involved in the experience of freedom.

A.3. Therapy as client-following exploring

The findings of E5.4 and E5.8 indicate how we must understand the experienced learning process involved in ET and suggest one component of the dynamic that brings this learning process about. The findings show that participants essentially experience therapy as an exploring, which is not directive. That is, a process that does not operate through the therapists controlling, giving advice or fixing but through the dynamic of following the clients agenda.

Maria, Martha, Niels and Karen articulate therapy as an opening, clearing, exploring or unfolding through questioning, testing, reflection or perspectives (E5.4). Niels: *"...I could actually explore who I am in this, what is happening with me, how I can also see some things, how I can contain" (I4.N1).*Niels gives detailed descriptions of his experience of therapy as a process of exploring and opening for learning that works through testing and reflection. Likewise, Maria, Martha and Karen

articulate lived experiences of therapy as a process of clearing or unfolding, that works through perspective and questioning. My findings suggest that ET is experienced as a particular learning process, working as an exploration through a dynamic of questioning, testing, reflecting and bringing new perspectives to bear on the participants self and life.

Maria, Niels and Klara articulate the experience of therapy as a client-following focus on the client's agenda that works without categorizing, fixing or giving advice (E5.8). Maria: *"Not try to be fixed. Have to find the answers, not get any advice, not being put in a box"* (I2.M10). Maria's experience has particular significance because she compares it to her experience of a previous course of therapy. As opposed to her previous experience, Maria articulates her experience of ET as a client-following process, in which she has to find the answers herself without getting any advice from the therapist. Furthermore, she articulates ET as a very client-following process because it was not about fixing her or categorizing her, rather it had a focus on her agenda. Niels' experience also has particular significance, because he initially experienced the therapist as being too directive and controlling (I4.7, I4.36). After confronting the therapist, Niels experienced therapy changing into a client-following and non-controlling process, which had a focus on his agenda.

A.4. Therapy as meeting involving taking ownership

The findings of E5.7 give further indication to how we must understand the experienced learning process involved in ET and suggest another component of the dynamic that brings about this learning process. The findings show that participants essentially experience therapy as a meeting that involves the client taking ownership.

Maria, Martha, Niels and Klara either articulate an experience of therapy as a meeting or as the client taking ownership or giving herself or himself to the therapist. Maria and Martha articulate an experience of therapy as a common space for meeting, characterized by being caring, close and non-judgmental (I2.M56, I3.M48). Niels articulates an experience of therapy as based on a commonness, where the client must take ownership and responsibility for the sessions (I4.M53-4). Klara articulates an experience of therapy as a safe space, where she gives herself to the therapist and has to find her own answers (I6.57, I6.61, and I6.53). The essence of these articulations is an experience of therapy as a learning process that works as a meeting through a relational dynamic. This relational dynamic involves qualities like closeness, commonness, care, giving and non-judging. The findings suggest that the learning process requires the client to takes ownership or responsibility for the process.

B. Therapist

The findings also indicate how the group of participants from ET perceive the therapist in therapy overall. In this sense, the findings of three recurrent themes indicate what role and function the therapist has for therapy as frame and process of learning (E5.2, 5.9, 5.10):

All participants articulated a lived experience of the therapist as talking or being with the client (E5.2). This finding indicates the participant's perception of the therapist's function in therapy. Martha; *"... someone who was with me. Support, a support"* (I3.M51). Martha describes the therapist as a midwife who works in therapy by giving her support. The findings indicate that the therapist functions in therapy by talking and being with the client. Thus, all participants somehow

perceive ET as a learning process that works through the therapist being with or for them through what the therapist says.

All participants have a lived experience of the therapist as a guiding, engaged, knowing or aware partner or companion (E5.9). These findings indicate the participants' perception of the therapist's role in therapy. Alma: *"I really had a good guide, who helped me get where I wanted to go"* (I1.B44). The perceptions of the therapist as a companion or partner indicate that the therapeutic relationship is important to learning in therapy. Furthermore, it indicates that this learning partly works through the dynamic of the therapist taking the role of a partner or companion for the client. This companion operates through qualities of guiding, knowing, being aware and engaged in the therapeutic relationship.

Maria, Martha and Klara articulate a lived experience of recognising the therapist as a support, midwife or revelator (E5.10). These findings give further indications of the therapist's function in therapy. Maria describes the therapist as a revelator, Martha as a midwife and Klara as a support. I have chosen to sum up the essence of these findings in terms of the role of assisting revelator. Thus, the findings suggest that the participants perceive the therapist as working by assisting in the revelation of learning, and the therapist does this through the relational quality of recognising the client.

5.1.6. Existential therapy master theme 6 (E6): Evaluation of outcome and process

Master theme E6 concerns the participants overall evaluation of therapy (Appendix 13):

Master theme E6

Positive therapeutic relationship and choice of approach as important for intense and demanding learning process and positive learning outcome.

The findings from E6 indicate what the participants find especially important about therapy or how they evaluate the learning process and outcome of ET. This involves findings concerning the learning outcome and learning process as well as of the therapeutic relationship and approach.

A. Therapist and therapeutic relationship

The first finding from one recurrent theme concerns the participants' evaluation of the therapeutic relationship. All participants articulate a lived experience of the importance of the therapeutic relationship in varied forms (E6.1). Niels: *"... it was very beneficial that I was with a psychologist, in a therapeutic relation, and not in a coaching relation" (I4.N1)* and *"... going into therapy is just as much about choosing the approach, which the therapist brings. Finally, it is also about choosing the therapist" (I4.N3)*. Niels articulates the importance of the therapeutic relationship for therapy and states that choice of therapist has an importance to therapy. Other participants describe how they value either their therapist or the therapeutic relationship as an important aspect of their experience and evaluation of therapy. Thus, these findings suggest that the choice of therapist and

the quality of the therapeutic relationship are significant for the participants' perception of therapy and its learning process and outcome. Furthermore, these findings are interesting, as choice of therapist was not a recurrent factor in the findings to do with the motivation and decision to enter therapy.

B. Therapeutic approach

The second finding concerns the participants' evaluation of the significance of the therapeutic approach. Three participants, Maria, Niels and Klara, articulate an experienced importance of the therapeutic approach (E6.3). Niels had a previous knowledge about ET and at several points; he articulates the importance of this approach for his engagement in therapy (e.g. I4.N3). Klara articulates a positive evaluation of the existential approach and states that especially the philosophical dimension of ET fits her personality (I6.K62). Maria has more modest claims, and states that nothing is worse in the existential approach (I2.54). These findings suggest that either the existential approach fits the participants from ET especially well, or the participants just articulate a positive evaluation of it. Whereas Karen states that she does not know whether it was the approach or the choice of therapist, which benefited her (K35), neither Alma nor Martha articulates anything on the therapeutic approach. Since these findings suggest an importance of the choice of therapy for the learning process and outcome of therapy, it is interesting that choice of therapy did not appear as a recurrent theme to do with the decision for therapy. Only Niels stated that a specific choice of ET was part of his decision for going into therapy.

C. Therapeutic outcome

Maria, Niels, Karen and Klara articulate experience of therapy as involving a positive or fulfilling outcome (E6.2). Niels stated that the good thing about therapy was that it actually had the positive outcome of change (I4.N34), Klara stated that therapy had the positive outcome of fulfilling her wish of learning to know herself (I6.K13).

D. Therapeutic process

Maria, Martha and Karen articulate therapy as involving an intense, hard or difficult learning process (E6.4). Like Martha, who describes the anxious process of finding her values and learning to accept uncertainty: *"...I do not know what will happen now and that is great. However, it has also been filled with anxiety to get there" (I3.M26).*

5.1.7. Summary of findings from existential therapy (ET)

The finding of E1 illustrate that participants from ET had a varied yet existing motivation for going into therapy.

Overall, most participants have decided to go into therapy based on an experience of poor well-being or a mental problem. Furthermore, half the participants articulate a wish for self-knowledge as the reason for their decision. Thus, issues and efforts to do with self and life seem to constitute the main background for deciding to go into therapy.

The participants articulate initial wishes for a therapeutic outcome of either authenticity or self-insight or of improvement of their mental state, closely related to their reasons for going into therapy. Half the participants articulate an initial wish for a therapeutic process of in-depth exploration of their self. Thus, the participants articulate wishes for the process and outcome of therapy as exploration and development of insight and capabilities for self and life. This is closely related to the articulation of issues and efforts to do with self and life as the main reason for going into therapy.

More than half the participants articulate an initial or gradual expectation of a positive outcome of therapy as insight and capabilities for self and life, closely relating to their initial wishes and reasons for going into therapy. Thus, the reasons, wishes and expectations for therapy center on self and life.

Importantly, there is no recurrent indication of the participants' decisions to enter therapy as based on a specific choice of therapeutic approach or therapist. Furthermore, there is no recurring pattern around any other details of their decisions. That is, this group of participants' decisions to go into therapy is primarily based on the experience of lack of well-being, mental problems or wish for self-insight. Issues to do with therapeutic approach and therapist as well as foregoing procedures of information seeking and discussions with others do not seem to have a unique importance.

The findings of E2, E3 and E4 illustrate major learning outcomes regarding self and life, thinking, acting and feeling and relationships with others.

1. Firstly, the finding of E2 indicate that most of the participants from ET initially experienced some kind of problematic self-relation or problem to do with direction in life. This is even though some

participants simultaneously expressed an experience of a positive self-relation, which however seems narrowly centered on professional performance. A previous experience of a partially problematic self-relation seems to be a common feature for participants from ET.

A prominent learning outcome of ET is a more authentic, caring and valuing relation to oneself. Closely related, a “changed self-image” appears to be another major learning outcome of ET. Thus, according to the lived experience of the participants, ET involves facilitating a profound learning of care and authenticity to do with the relation to and image of the self.

Another major learning outcome is developing a better sense of personal life values. Closely related is an experienced learning outcome of more engagement and satisfaction in life. These aspects are followed by the experienced learning outcome of a more open and courageous approach to life. Furthermore, learning sense of direction in life, learning to accept anxiety and live with freedom and learning more engaged participation in hobbies and communities are recurrent learning outcomes, albeit slightly less frequent. Thus, according to the lived experience of the participants, ET involves facilitating a thorough learning regarding values, engagement, approach, direction, freedom and uncertainty in life.

These significant findings on experienced learning for life and self, match the participants' initial wishes, hopes and expectations for a learning outcome for life and self.

2. Secondly, the findings of E3 indicate that most participants from ET articulate a lived experience of previously lacking capabilities for coping with difficulties, taking responsibility and making choices. Half the participants also articulated a lived experience of previously lacking understanding and coping with feelings of anxiety.

The participants articulate a lived experience of learning capabilities for coping with difficulties and making genuine choices as a learning outcome of ET. Furthermore, most participants articulate the learning of abilities to take responsibility, to react calmly, to act from their own position in life and to think openly. These findings are important, since the participants experienced previous difficulties within these areas.

3. Thirdly, according to the finding of E4, most participants articulate the experience of a previous problematic way of relating or tendency to other-focus in relationships. Furthermore, most participants articulate a previous lack of ability to be oneself and engage in mutual relationships.

All participants articulate the lived experience of learning capabilities for engaging in mutual relationships. Furthermore, most participants articulate the lived experience of a learning outcome of learning to be oneself in relationships. Finally, half of the participants articulate the lived experience of a learning outcome of learning capabilities to set limits and respect others in relationships. These learning outcomes are especially important, because most participants articulate a previous experience of lacking capabilities within these fields. Thus, “learning capabilities for engaging in mutual relationships as oneself with abilities to set limits and respect others”, is a major experienced learning outcome of ET.

These findings seem especially significant because a learning outcome to do with relationships was not a recurrent wish, hope or expectation amongst the participants; were neither relational problems nor relational wishes a recurrent reason for going into therapy.

Moreover, these findings indicate that participants may formulate their previous experiences in light of their experienced learning outcome.

The findings of E5 indicate how we must understand the learning processes involved in ET and how they are brought about.

The findings indicate that the participants experience ET as an in-depth and caring learning space for transforming the client's self, and a learning process, teaching insight, courage and the valuing of life alongside acceptance of the uncertainty of freedom in life. These findings correlate with the participants' initial experience of wishes for self-insight or problems and lack of well-being in life. These are their reasons for going into therapy, with a hope for self-knowledge, authenticity and capabilities for living. Furthermore, they match the findings of a major learning outcome of learning authentic and caring relation to oneself, changed self-image and a more open and courageous approach to life.

The findings indicate that this learning of self and life partly works as a client-following process of exploration of the clients' selves and lives. This process works through a dynamic of questioning, testing and reflecting, which follows the clients' agenda. The findings suggest that this learning process requires that it does not control or direct the client and does not attempt to fix, categorize or advise the client.

The findings indicate that this client-following learning process of exploration furthermore works as a meeting between therapist and client through a relational dynamic, which has the quality of being caring, close and non-judging. Furthermore, the findings indicate that the learning process requires that the client engages in and takes ownership of it.

Thus, the learning to do with self and life works with a therapist who is client-following and engages in a caring and non-judgmental meeting with the client with the aim of following the client's agenda.

The findings indicate that the learning process to do with self and life involves that therapist taking up the role of companion for the client. This companion functions in the learning process by being with and for the client in his or her learning and by assisting the revealing of this learning through recognition of the client.

Hence, participants experience ET as an in-depth and caring learning space for a transformation of the self and a learning of courage and valuing life with acceptance of the uncertainty of freedom in life. This learning is generated by a client-following process of exploring the clients self and life. Furthermore, this process of exploring works as a meeting between therapist and client through a relational dynamic, which has the quality of being caring, close and non-judging and demands that the client take ownership of the process. In order to facilitate the in-depth and caring learning space the therapist must take on the role of a companion for the client who works in the learning process by being with and for the client in his or her learning and assisting the revealing of this learning through recognition of the client.

Summing up, the findings indicate a correlation between:

(a) Perceiving therapy as an in-depth learning space for transformation of the self and insight into life through client-following exploration within a non-judging meeting with a strong relationship to a recognizing and assisting companion.
(b) Experiencing the learning outcome of therapy as caring and authentic self-relation and the capability for open and valued living with abilities to cope with difficulties and engage in mutual relationships as oneself.

These findings relate to the experience of ET as involving a positive and fulfilling learning outcome through an intense and demanding learning process related to the initial experiences of a lack of well-being to do with the self and life and wishes for self-knowledge.

Moreover, the evaluation of the therapeutic relationship as having a significant importance for the experience of learning in ET supports the findings of the relationship to the therapist as a crucial dynamic in the process of learning. The evaluation of the therapeutic approach as having significant importance also support the findings of ET as a specific design for an in-depth learning space for transformation of the self with capabilities and insight for life.

Furthermore, the findings of E6 show that ET is experienced as having a positive and fulfilling learning outcome. The findings also point out that participants experience this fulfilling learning as the result of an intense and demanding learning process.

5.2. CBT

In this section, I present my findings on CBT by focusing on the six master-themes. In appendix 14-19, I present each master theme along with a secondary table of the subsumption of recurrent super-ordinate themes for this particular master theme. This secondary table shows whether the recurrent super-ordinate theme is present for each participant.

5.2.1. CBT master theme 1 (C1): Motivation

The first master theme concerns the motivation for going into therapy in the group of participants from CBT (Appendix 14):

Master theme C1

High motivation for therapy reflecting in choice of therapist based on depression, anxiety and stress or emotional burden. This related to wider life problems with hope for outcome as fixing or improvement of mental state. Expectation of learning of tools for coping.

A. Motivation and decision

The first findings from four recurrent themes (C1.1-4) concern the different aspects to do with the participants' initial psychological motivation and decisions for going into therapy.

A.1. Psychological motivation

The first finding indicates that five participants had a high or even increasing psychological motivation for starting therapy (C1.1.). Anna, Lea, Svend, Sune and Carl all express an initial high motivation for therapy (I7.N5, I8.L9, I9.S6, I11.S1, and I12.C8). Furthermore, Sune described how his motivation increased due to his experience of change: *"Many things came up that I would not have been able to find myself. That made me want to go on. I could feel that some things happened" (I11.S5)*

A.2. Decision making

The findings of four recurrent themes (C1.2-5) concern the decision and show how participants based the decision to go into therapy on a mental problem and/or emotional stress. The decision was related to life problems and to an informed choice of therapist.

Lea, Svend, Thor and Carl describe their decision to go into therapy as based on the experience of a mental problem of anxiety, stress or depression (C1.2). Thor: *"... I have been in treatment for um anxiety. Panic anxiety" (I10.T2)*. They all tend to articulate the understanding of their problem in clinical terms. Lea uses the term "anxiety" nine times; Svend uses the term "anxiety attack" once, the term "anxiety" twice and the term "depression" once; Thor uses the term "panic anxiety" twice and the term "anxiety" six times; and Carl uses the term "stress" nine times and the term "panic anxiety" twice. Furthermore, Thor describes his problem as a disease 6 times and Carl articulates his problem as a disability once. In particular, Thor and Carl articulate that they have picked up the clinical conception of their problem from therapy. Thus, neither Thor nor Carl was able to conceptualize his problem in clinical terms before he went into therapy. However, Carl partly seems to have started clinical conceptualization in a previous course of therapy and then maintained it in CBT. The findings do not show whether Lea and Svend picked up clinical terms from CBT. Put together, there is a minor indication that clients may pick up or maintain a clinical conceptualization of their problem from CBT.

Anna, Sune and Carl said that their decision to go into therapy related to an initial experience of emotional stuckness, burden or problem (C1.3). Anna told me that she was carrying an emotional burden and needed peace (I7.N5). Svend told me that he had problems coping with everyday life after a divorce (I9.S1). Sune told us that he needed a clarification regarding problems in his

relationship (I11.S1). Carl told me of lack of well-being with mood swings (I12.C1, I12.C5, I12.C12, and I12.C14).

Svend, Sune, Thor and Carl told how their decision to go into therapy related to a concrete problem at work, in their life or relationship (C1.4). For Sune and Svend their decision related to relationship issues. Svend: *"I had recently been divorced and I experienced that is was difficult for me to cope with everyday life just after a divorce" (I9.S1).* Thor and Carl both based their decision in relation to experiencing problems at work (I10.T1, I12.C1).

Anna, Lea and Carl made their decision of therapy with an informed or reflected choice of therapist (C1.5). Carl: *" I thought well something around that and just looked on the internet to see who looks reasonable and who is within a distance from, from what is possible to get to and from, so it will not be a giant thing to get there" (I12.C1).*

B. Hopes and expectations for therapy

These findings concern the participants' initial hopes and expectations for the outcome of therapy (C1.6-8). The participants from CBT hoped for an improvement or normalization of their mental state and/or tools for coping.

B.1. Hope for improvement or fixation

Lea, Svend, Thor and Carl articulate an initial hope for serenity, relief or improvement of their mental state (C1.6).

Furthermore, for Svend, Thor and Carl this hope related to a hope for or expectation of a fix, normality or an easier life (C1.8). Svend: *"Well, I just hoped to get something. To get, I actually think, I hoped that he could fix it, that is was like that, make it go away" I9.S4).*

Thor hoped for a relief of symptoms and an easier life, and Carl hoped to become normal again in his work-life (I10.T9, I10.T11, and I10.C6).

B.2. Hope or expectation for learning tools and abilities for coping

Anna, Lea, Thor and Carl articulated an initial hope or expectation for learning tools or abilities for coping with anxiety, problems or thoughts (C1.7). Anna stated it like this: *"...I think that it could give me some tools"* (I7.N7). Lea articulated a hope for tools for coping with anxiety (I8.7), Thor to learn to cope with his symptoms (I10.T9); and Carl hoped for abilities for a more balanced approach to his work (I12-C6).

5.2.2. CBT master theme 2 (C2): Self and life

The finding of the second master theme concerns the learning outcome to do with self and life (Appendix 15):

Figure f20: Master theme C2

Learning capabilities for capable, caring and valuing self-relation, with more positive self-image and better self-esteem. Following own values and direction in life with an open approach to life

and participation in the world. In contrast with previous negative self-relation and self-image with lack of abilities for sensing and following values and direction in life.

A. Previous experiences to do with self and life

These findings concern the participants' previous experiences to do with self and life (C2.1-3).

A.1. Previous negative self-relation

The findings of two recurrent themes (C2.1, C2.3) indicate that most participants remembered an experience of a previous negative self-relation.

Anna, Lea, Sune and Carl describe previously having had a negative self-image (C2.1). Sune: *"... on many levels I saw myself as a victim [..] A victim to the conditions of things, to other people and my situation" (I11.S8).*

Likewise, Anna perceived herself as a control focused and impatient person (I7.N20), Lea as a fluid and over-thoughtful person (I8.L16), and Carl as a performance oriented and dissatisfied person not being good enough (I12.C13).

Lea, Svend and Carl expressed a negative relation to themselves by having low self-esteem, a feeling of inferiority or causing trouble for themselves (C2.3). Carl: *"I could somehow see that I am extremely demanding, self-critical" (I12.C4)*. Carl was dissatisfied with himself and criticized himself,

causing trouble for himself. Lea felt insecure and inferior about herself as not having an equal right to exist (I8.L17), and Svend had a very low self-esteem (I9.S11).

A.2. Previous lack of abilities for values, control and direction in life

Anna, Lea, Sune and Carl expressed a previous lack of sensing or following their life values or having control of or direction in life (C2.2). Carl: *"I came from a situation with a feeling that there was no direction. That is, it was standing still. In my head, in my eyes, it just did not work at all" (I12.C25).* Carl lacked a feeling of direction. Anna felt she lacked abilities for standing up for her values and following her direction in life (I7.N6). Lea and Sune had a confused sense of direction in life and did not feel in control of themselves (I8.L40, I11.S14).

B. Learning outcomes to do with self and life

These findings concern the participants' learning outcomes to do with self and life (C24-10).

B.1. Learning outcome of a more caring, valuing and capable self-relation

The findings of four recurrent themes (C2.4-6, C2.8) indicate that learning a more caring, valuing or capable self-relation is a major learning outcome of CBT.

All participants from CBT tell of becoming more capable of self-care, self-structure or self-awareness (E2.4). This result seems important, as most participants previously had a negative self-relation.

Svend; "*I was able to remove focus from other people and shift it towards myself"* (I10.S33). Svend became more self-focused and self-caring whereas previously focused on others and had low self-esteem.

All participants changed their self-image from therapy (E2.5). Thor learned a more humble and analyzing image of himself (I11.T20). Anna, Lea, Svend, Sune and Carl all learned a more positive perception of themselves with a more valuing, capable, aware, present or authentic self-image (C2.6). This result is important since most participants previously had a negative self-image.

All participants express what seems to be a major learning outcome of better self-esteem (E2.8). One of them is Anna; *"... my own self-esteem did get better" (I7.N28).*

B2. Learning an open approach to life with the ability to follow one's own life direction

The findings of two recurrent themes (C2.7, C2.9) indicate that learning a more open approach to life and following one's own life direction is a significant learning outcome of CBT. These findings are significant since most participants expressed a previous lack of sensing or following their life values or having control or direction in life.

Five participants articulate learning a more open, enterprising or relaxed approach to life (C2.7). Lea: *"To have permission to be on earth? It is a liberation. Yes, at feel equal being, or have equal right to be" (I8.L69).* Lea feels liberated with a freer approach to life. Likewise, Svend, Thor, Sune and Carl articulate similar experiences in varied forms.

Anna, Lea, Thor, Sune and Carl express learning more control, personal strength, security, groundedness or the ability to follow their own direction in life (C2.9). Thus, Anna describes becoming capable of standing up for her own values and following her own direction in life whereas she used to lack this capability (I7.N36). Likewise, Lea articulate becoming more mature, grounded and capable of sensing and holding on to her personal values (I8.L26, I8.L29, I8,L37), and Sune articulates the experience of having clarified his values and becoming able to stand by them (I11.S16). Thor articulates an experience of more personal strength, yet he senses no change in his values and direction in life (I10.T19, I19.T30). Carl describes getting more direction in life related to his previous experience of lacking direction in life (I12.C25).

B.3. Learning outcome to do with participation in communities and hobbies

This finding of one recurrent theme (E2.10) concerns the ability to participate in communities and hobbies. Thus, Lea, Sune and Carl express an experience of becoming more capable of engaging in communities and hobbies. Lea: *"If I have been more outgoing in those? Yes, but it has also become more certain to me, what I do not want" (I8.L64).* Lea articulates an experience of getting more engaged in preferred communities, while she also is more able to extricate herself from communities that she does not want to take part in.

5.2.3. CBT master theme 3 (C3): Thinking, acting and feeling

The second master theme concerns learning outcomes to do with thinking, acting and feeling (Appendix 16):

Master theme C3

Learning capabilities for organizing thoughts, coping with difficulties, and handling responsibility and choices, with an appropriate and reflected way of acting and thinking, and a relaxed way of reacting. As opposed to a previous lack of abilities for coping with difficulties and a problematic way of thinking and acting.

A. Previous experience of thinking, acting and feeling

The findings of four recurrent themes (C3.1-4) concern the participants' experience of their previous thinking, acting and feeling.

A.1. Previous lack of abilities for coping with difficulties and feelings

These findings concern the participants' previous lack of abilities for coping with difficulties and feelings (C3.1-2).

Anna, Lea, Svend, Sune and Carl express a previous lack of abilities for coping with difficulties and solving problems (C3.1). Sune: *"I avoided conflicts um and It was difficult for me to bear to handle*

difficult situations" (I11.S17). Sune describes how he used to lack the abilities for coping with difficult situations.

Lea, Thor and Carl express a previous experience of lacking abilities to understand or cope with anxiety and anxious situations (C3.2). Lea: *"Anxious to anxiety [..] I felt that it engulfed me. That I was not master in my own house, but it was master over me" (I8.L39-40)* Lea felt controlled by anxiety. Likewise, Thor lacked the ability to cope with anxiety and did not understand what it was (I10.T5). Carl articulates the experience of previously having had an insecure and anxious way of reacting (I12.C20).

A.2. Previous problematic way of thinking and acting

These findings from two recurrent theme concern a previous problematic way of thinking and acting (C3.3-4).

Anna, Lea, Sune and Carl tell of a previous inappropriate pattern of thinking or acting (C3.3.). Anna tells how she used to have a tendency to over-plan and go into negative thought carousels (I7.N1). Lea tells of a previous tendency for over-thoughtfulness (I8.L19), Sune of having had an inappropriate pattern of over-adjusted thinking and acting (I11.S26), and Carl of having a pattern of thinking in spirals (I12.C14).

Anna, Lea and Svend tell of a previous lack of ability to understand, organize or reflect on their own thoughts or behavior (C3.4). Anna tells how she used to lack the ability to organize her thoughts and

be in the moment (I7.N22), Lea how she used to lack the ability to reflect on her own behavior (I8.L57), and Svend how he lacked an understanding of his own thoughts and actions (I9.S9).

B. Learning outcomes to do with thinking, acting and feeling

These findings of five recurrent themes (C3.5-9) concern the participants' experience of learning outcomes to do with their way of thinking, acting and feeling. One participant, Svend, describes how he did not experience a permanent change on an overall level in this area and had a subsequent relapse into his previous patterns; *"...it did not help on an overall level to create a permanent change"* (I9.S22). However, the rest of the participants experienced learning outcomes in this area.

B.1. Learning capabilities for problem solving and coping with difficulties

Anna, Lea, Thor, Sune and Carl spoke of becoming more capable of solving problems and coping with difficulties and anxiety, as compared with a previous lack of these capabilities (C3.5). Thor: *"I think that where I have changed due to treatment, that is, I no longer say no to such situations, that I used to avoid" (I10.T39)*. Thor articulates having learned to confront and deal with anxious situations, as opposed to his experience of previously lacking the ability to understand and cope with anxiety and anxious situations.

B.2. Learning capabilities for appropriate and reflected ways of thinking, acting and reacting

The finding of three recurrent themes concern learning capabilities for more appropriate and reflected ways of thinking and acting (C3.6-7). These findings are important, because most participants told of a previous lack of abilities for understanding, organizing and reflecting on thoughts and behavior or an inappropriate pattern of thinking or acting (C3.3-4).

Anna, Lea, Sune and Carl express becoming more capable of organizing thoughts or having learned a more capable way of thinking (C3.6.). Anna: *"...that I am a person who can be in the moment and is less anxious for not making it all"* (I7.N25). Anna told of a previous tendency to over-plan, negative thought patterns and a lack of ability to be in the moment (I7.N1). She expressed becoming capable of organizing thoughts and being in the moment from therapy.

Lea, Thor, Sune and Carl articulate the lived experience of becoming capable of behaving and acting in a reflected way (C3.7). They all had previous experiences of problems to do with their way of thinking and acting. Sune: *"I experienced that um that I acted on that I started to believe more in myself and started to act on what I thought was right and wrong [..] Now I could trust that my own starting point was right" (I11.S11).* Whereas Sune used to have an inappropriate pattern of over-adjusted thinking and acting, he expressed having learned to act and think from an increased belief in himself and his own position.

Anna, Lea, Sune and Carl said that they have become more capable of reacting in a reflected, resistant or relaxed way (C3.9.). Anna said that she has learned a more resistant way of reacting (I7.N8); Lea is reacting in a more reflected and determined way (I8.59); Sune has become more

capable of active reacting from a sense of self-acceptance (I11.12); and Carl has a more relaxed way of reacting, related to his previous anxious way of reacting (I12.C27).

B3. Learning capabilities for taking responsibility or making choices

The findings of one recurrent theme (C3.8) show that Anna, Lea, Sune and Carl have become more capable of handling responsibility or making choices. Carl: *"...there is something that is your problems and something that is my problems"* (I12.C24). Whereas Carl used to feel over-responsible and take responsibility for others, he has learned to separate his own responsibility from others (I12.C20, I12.C24). Anna, Lea and Sune articulate the experience of becoming more able to take responsibility and make reflected choices (I7.N50, I8.L62, and I11.S21).

5.2.4. CBT master theme 4 (C4): Relationships with others

The fourth master theme concerns the learning outcome to do with relationships with others (Appendix 17):

Master theme C4

Learning capabilities for being oneself as an independent person, and engaging in self-chosen mutual relationships with abilities for accepting, coping with criticism, and setting limits. Compared to previous problematic way of relating and lack of ability to be oneself in relationships.

A. Previous experiences to do with relationships with others

The findings of four recurrent themes (C4.1-4) indicate that five of the participants from CBT previously experienced problems in their relationships with others.

A.1. Previous problematic way of relating to others

The findings of three recurrent themes (C4.1-3) point to a previous problematic way of relating to others among most of the participants from CBT.

Lea, Svend, Sune and Carl articulate varied experiences of previously being submissive, role playing or controlled by other focuses in relationships (C4.1). For example, Lea previously had a tendency to be submissive and feel inferior in relationships (I8.L23); Svend, used to be controlled by an other-focus and think that people mostly acted to bother him (I9.S20).

Lea, Thor and Carl describe previous problems with setting limits for others or to do with criticism from others (C4.2). Carl: *"Difficult situations […] probably there has been a tendency to um for instance to be criticized. To be praised but also to be criticized. I felt difficult about that" (I12.C26).* Thus, Carl had difficulties to do with criticism from others.

Lea, Svend and Carl express the experience of previously lacking connectedness in relationships or being over-responsible for others in relationships (C4.4.). Lea told of a previous lack of ability to engage in mutual relationships (I8.L42); Svend did not really connect with anyone (I9.S23); and Carl was over-responsible for others (I12.C20).

A.2. Previous lack of ability to be oneself in relationships

Lea, Svend and Sune articulate a previous experience of lacking the ability to be themselves in relationships (C4.3). Sune: *"I used to think that if I do what they want then they must be happy. Then they cannot be anything but happy. That I submit to them" (I11.S20)* Sune told how he used to be pleasing and therefore lacked the ability to be himself in relationships.

B. Social persons

The findings of one theme (C4.5) show that half of the participants from CBT, Anna, Sune and Carl, articulate themselves as social persons with significant relationships, regardless of their learning outcome. Thus, these findings suggest that participants from CBT may be very relationally oriented and value relational issues highly, even though five participants experience problems to do with relationships with others.

C. Learning outcomes to do with relationships with others

The findings of four recurrent themes (C4.6-9) indicate that all the participants experienced learning outcomes to do with their relationships with others.

C.1. Learning capabilities for engaging in mutual relationships

The findings of two recurrent themes (C4.7-8) indicate that five participants experienced learning capabilities for engaging in mutual relationships. This finding is significant since most participants previously experienced problems regarding their way of relating or ability to engage in mutual relationships.

Anna, Lea, Thor and Carl tell that they have become more capable of accepting others, of being accepted by others, of coping with criticism or of setting limits for others in relationships (C4.7). Whereas Thor used to experience criticism from colleagues due to his avoidance behavior, he now experiences more acceptance from others due to his being open about his problems (T10.34-35).

Anna, Lea and Sune have become more capable of choosing their relationships and/or engaging in mutual relationships (C4.8). For example, Anna has become more selective about her relationships (I7.N28).

C.2. Learning capabilities for being oneself as an independent person in relationships

The findings of two recurrent themes (C4.6, C4.9) indicate that five participants from CBT have learned capabilities for being themselves as independent persons in relationships. These results are important because many participants previously had trouble in this respect.

According to the findings, Anna, Lea, Svend, Sune and Carl have become more capable of being and/or understanding themselves in relationships (C4.6). For example, Sune used to please others but has become able to be himself in relationships (I11.S20), and Carl used to be over-responsible but now feels calmer about being himself in relationships (I12.C31).

Furthermore, the findings show that Lea, Svend and Carl have become more able to separate themselves from others, be independent in relationships or have less focus on other things (C4.9). Lea is more able to engage in mutual relationships as an independent person (I8.L43, I8.L50).

5.2.5. CBT master theme 5 (C5): Therapy and therapist

The fifth master theme concerns the participants' perception of therapy and therapist (Appendix 18):

Master theme C5

Therapy as an educational framework for learning opening of perspectives and focusing on positive self-awareness through tools for coping with thoughts, feelings and actions. This based on specific therapeutic techniques and questioning, utilizing the relationship with the therapist as guiding teacher and friendly partner for sparring.

A. Therapy

The findings of six recurrent themes (C5.1-7) indicate the participants' lived experience of therapy as an educational framework for learning tools for coping based on specific techniques:

A.1. Therapy as an educational framework for learning or self-change

One recurrent theme (C5.1) indicates that most participants perceive CBT as a learning directed framework. Thus, Anna, Lea, Svend, Thor and Sune articulate an experience of therapy as an educational framework for learning or self-change (C5.1). Anna articulates therapy as a professional framework for a demanding self-change (I7.N23); Lea as an education that needs one to pull oneself together (I8.L30; I8.L83); and Svend as a directive and rigorous learning to work on one's self (I9.S28, I9.S30). Thor sees therapy as an education on mental disease with a learning of tools and self-care (I10.S13, I10.S45); and Sune as a reflected process of self-learning (I11.S24).

A.2. Therapy as opening of perspectives and a focusing on positive self-awareness

The findings of two recurrent themes (C5.4-5) indicate how we must understand the experienced learning process involved in CBT and suggest two components of the dynamic, which brings this learning process about. The findings show that the participants essentially experience therapy as an opening of perspectives involving positive self-awareness.

Anna, Lea, Svend and Sune perceive therapy as a sharing, exchange or opening of perspectives of self, life or ways of acting (C5.4). Lea describes therapy as an opening of new perspectives on her ways of acting (I8.L77). Likewise, Anna describes therapy as involving the drawing of a picture of her life (I7.N13); Svend as an exchange of perspectives (I9.S28); and Sune as a clarification and helpful opening up of new doors for self and life (I11.S26).

Lea, Thor, Sune and Carl articulate an experience of therapy as a focusing on increasing self-esteem, self-care or positive awareness (C5.5). Carl: *"... after a while I could see that it actually does make a*

difference to balance self-criticism. I actually look quite deliberate on what has actually been good enough, do I do all right during the day" (I12.C24).

Carl talks of therapy as a focusing on positive awareness; Lea as a focusing on self-esteem and self-work (I8.L83); Thor as self-care (I10.T13); and Sune as a self-focused process of learning (I11.S24).

A.3. Therapy as based on specific therapeutic techniques and directed at learning tools for coping

The findings of two recurrent themes (C5.2-3) give further indication to how we must understand the experienced learning process involved in CBT. It suggests two more components of the dynamic that brings this learning process about. The findings show that participants essentially experience therapy as a learning process, directed at tools for coping and based on specific therapeutic techniques.

Anna, Lea, Thor, Sune and Carl perceive therapy as directed at learning tools for coping with anxiety or organizing thoughts or behavior (C5.2). Thus, five participants have almost similar experiences of therapy as providing specific or technical tools for perceiving, identifying, organizing or coping with thoughts, actions or feelings (I7.N30; I8.L78; I10.T45; I11.S29; I12.C14).

Lea, Thor, Sune and Carl perceive therapy as based in specific therapeutic techniques, like questioning, schemas or homework (C5.3). Thor: *"I was afraid that I would meet someone who could read me like an open book. However, he does the same as I do for costumers in the bank. He just asks some questions, and then I come up with the answer. We use the same techniques to customers" (I10.T45)* Thor and Sune describe therapy as based on techniques for questioning

(I11.S5), whereas Lea and Carl articulate schemas and/or homework as essential techniques for the therapeutic learning process (I8.L81; I12.C14).

B. Therapist

The findings also indicate how the group of participants from CBT perceive the therapist overall. This indicates what role and function the therapist has for learning in CBT and that CBT relies on a strong therapeutic relationship (C5.6):

Anna, Lea, Thor and Sune express varied perceptions of the therapist as a friendly, emphatic or reassuring guide, teacher or sparring partner. Anna saw the therapist as a friendly guide (I7.N64); Lea as an emphatic teacher (I8.L81); Thor as a friendly and reassuring questioner (I10.T12, I10.T45); Sune as a questioning sparring partner (I11.S5); and Carl as a reassuring professional (I12.C14). Thus, most participants perceive the therapist as working through an educational or learning (questioning) dynamic. Furthermore, this dynamic seems to have relational qualities such as empathy, friendliness, partnership or reassurance.

One participant, Svend, perceived the therapist as a motivator with a rather strong attitude who was working very directly (I9.S11, I9.S28). Thus, Svend seems to perceive the therapist and therapy in slightly different educational terms than the rest of the CBT participants. Quite interestingly, Svend is the only participant who perceives the therapy and therapist in heavily asymmetric and directive terms. In addition, Svend is also the only participants who expresses not experiencing a permanent change from therapy but relapsing into his old patterns after the end of therapy.

5.2.6. CBT master theme 6 (C6): Evaluation of outcome and process

The final master theme concerns the overall evaluation of the therapeutic learning process and outcome (Appendix 19):

Master theme C6

Importance of good therapeutic relationship, personality of therapist and effective therapeutic approach for the learning process and a positive outcome of therapy with minor disappointments

The findings of four recurrent themes (C6.1-4) indicate that due to the participants' evaluation of the learning process and outcome of CBT, they attach special importance to a good therapeutic relationship and the personality of the therapist, as well as an effective therapeutic approach.

A. Importance of positive therapeutic relationship and effective therapeutic approach

The findings of two recurrent themes (E6.1, E6.3) suggest that the character of the therapeutic relationship as well as of the choice of therapist and therapeutic approach have significance.

Five participants articulated varied experiences of the importance of a positive therapeutic relationship (E6.1). Carl articulates an experience of a good therapeutic relationship as crucial for the therapeutic learning process and outcome (I12.C37). Sune describes how therapy was based on sharing with the therapist, whereas Anna and Thor express the experience of a good therapeutic

relationship (I11.S6, I7.N63, and I10.T12). Lea directly expresses the importance of the choice of therapist and details different strengths and weaknesses to do with the concrete therapeutic relationship (I8.L83).

Four participants express the significance of therapy or the therapeutic approach (E6.3). Even though Lea places more importance on the personality of the therapist, she articulates the importance of the therapeutic approach, and made an informed choice of CBT (I8.L3, I8.L83). Carl likewise made an informed choice of CBT, and he highlights the importance of the CBT approach for his experience of effectiveness and states that it matches his personality (I12.C11, I12.C14). Thor and Sune indicate that this type of therapy is effective, though without mentioning the term CBT (I10.T10, I11.S6).

B. Positive outcome with minor disappointments to do with process and outcome

The findings of two recurrent themes (6.3-4) indicate a positive outcome with minor disappointments.

Lea, Thor, Sune and Carl express an evaluation of therapy as having the positive outcome of improving their mental state, allowing them to handle their relationships, or giving tools for coping with anxiety (C6.3). Carl experienced more well-being and a removal of his mental problems (I12.C14).

Anna, Lea and Thor express that they experienced disappointments or impatience about the therapeutic process or outcome (C6.4). Anna articulated an initial wish for concreteness but did not feel that the course was as concrete as she wished (I7.N14).

5.2.7. Summary of findings from CBT

The finding of C1 show that the participants from CBT had a high motivation for beginning therapy. For all participants their decision was based on the experience of a mental problem or a lack of well-being. Furthermore, to most participants their decision related to the experience of a concrete problem at work or with relationship issues. The findings suggested a minor tendency for articulating these mental problems in clinical terms.

There is an indication that participants from CBT related their decision to a reflected or informed choice of therapist. However, the findings do not suggest that choice of therapeutic approach was important for the decision of going into therapy. Neither do the findings suggest that other factors like recommendations or discussions with others had an effect on the decision to go into therapy.

The participants from CBT expressed having an initial wish for a fixing or improvement of their mental state with an expectation of learning of tools and abilities for coping with problematic feelings, thoughts and actions.

Findings indicate that participants from CBT previously experienced a negative self-relation with a low self-esteem and a negative self-image related to a lack of abilities to sense and follow their own direction and values in life. This experience linked to a problematic way of thinking and acting with

inappropriate patterns, and a lack of abilities for coping with difficulties and anxiety. Additionally, the participants from CBT were social persons experiencing a problematic way of relating to others, with a lack of ability to engage and be themselves in mutual relationships.

The experienced learning outcome of CBT was learning a more capable self-relation with better self-esteem and a positive self-image, associated with learning a more open approach to life with the ability to follow their own direction in life. This was linked to learning capabilities for coping with difficulties and handling responsibility and choices with an organized, reflected and relaxed way of acting, reacting, feeling and thinking. Learning capabilities for being oneself as an independent person and engage in self-chosen mutual relationships, with abilities for constructive relating were also connected.

The findings of C2, C3 and C4 indicate major experienced learning outcomes to do with self and life, thinking, acting and feeling and relationships with others. Thus, the experienced learning outcome of CBT relates directly to the experience of previous problems to do with self, life, thinking, acting, feeling and relating. Furthermore, to a certain extent, they link to the initial wishes for therapy and the participants' reason for going into therapy. This not only indicates a fulfillment of initial wishes and a solving of personal problems, but also indicate that participants may formulate their previous experiences in light of their learning:

1. Firstly, the finding of C2 show how participants from CBT tell of previously having had a negative self-image and a negative relation to themselves with low self-esteem, a feeling of inferiority or that they caused trouble for themselves. Furthermore, the participants articulate a previous lack of abilities for sensing and following their personal values and feeling control and direction in their lives.

The findings indicate that the participants from CBT have learned a more capable, caring or valuing self-relation with a changed self-image as a valuable, aware or present person related to their previous negative self-relation and negative self-image. Furthermore, the findings indicate that the participants from CBT have learned a more open approach to life with the ability to follow their own direction in life related to the experience of previously lacking abilities to sense and follow direction and their life values. Finally, the findings indicate that participants from CBT have become more capable of engaging in communities and hobbies.

2. Secondly, the finding of C3 indicate that the participants from CBT previously lacked abilities for coping with difficulties and/or anxiety. Furthermore, the findings indicate that the participants previously experienced having a problematic way of thinking and acting with inappropriate patterns and a lack of ability to reflect on their own thoughts and actions.

The findings point to a major experienced learning outcome from CBT to do with thinking, acting and feeling. Thus, the participants experienced learning capabilities for coping with difficulties and anxious situations, and solving problems. Furthermore, the participants experienced learning capabilities for a more appropriate and reflected way of thinking and acting, and for more resistant or relaxed reacting. Finally, the findings show that most participants have learned capabilities for taking responsibility and/or making reflected choices.

3. Thirdly, the finding of C4 show that most participants from CBT had an experience of previous problems in relationships with others to do with being controlled by other-focus, have boundary issues or a lack of the ability to engage in mutual relationships. Furthermore, the findings show that participants from CBT previously lacked the ability to be themselves in relationships. These findings

seem significant because they also indicate that participants from CBT are social persons who value relationships.

The findings of C4 indicate that learning relational capabilities is a major experienced learning outcome from CBT. Thus, the findings indicate that participants have learned to engage in self-chosen mutual relationships with abilities to accept, cope with criticism and set limits. In addition, the findings show that participants have learned to be themselves as independent persons in relationships.

The findings of C5 show that participants from CBT essentially perceive CBT as an educational framework for a learning process, which involves a self-change:

1. Firstly, the fundamental dynamic in this educational framework for learning is an opening of new perspectives of self, life and ways of thinking, acting and feeling. This opening seems to work through a focusing on positive self-awareness, which generates self-care, self-esteem and positive perspectives.

2. Secondly, this opening of new perspectives with a focusing on positive self-awareness operates through the clients learning of specific tools for coping with thoughts, actions and feelings. Furthermore, this learning process is based on specific therapeutic techniques like questioning, schemas and homework that generate the new perspectives with a focus on positive self-awareness.

3. Thirdly, in order to facilitate this educational frame for the learning of tools for new perspectives with positive self-awareness, the therapist must employ specific therapeutic techniques. The

therapist must also work as a guiding teacher who spars with the client and is able to establish a therapeutic relationship through relational qualities like friendliness and partnership.

These findings suggest a narrow correlation between the clients' experience of:

> (a) CBT as an educational framework for a learning process to do with learning positive self-awareness with tools for coping with thoughts, actions and feelings through techniques and perspectives on self, life and ways of thinking, acting and feeling.
>
> (b) A learning outcome of a positive self-relation and abilities to engage in mutual relationships with a capable life-approach and capabilities for coping with problematic thoughts, feelings and actions.

The findings of C6 indicate that participants evaluate the choice of therapist and the therapeutic relationship as important for the learning process and outcome of CBT. Furthermore, the findings indicate that the choice of therapeutic approach is important, which is interesting, because only two participants made an informed choice of CBT.

The findings also indicate participants experienced CBT as having a positive outcome related to their initial reason for going into therapy even though some participants experienced minor disappointments in the process and outcome of therapy.

5.3. Comparison of findings from Existential therapy (ET) and CBT

In this section, I present my comparison of the findings from ET and CBT by focusing on the two tables of the six master-themes. Following the common structures for these tables, I present each

master theme from ET put next to the associated master theme from CBT. The comparison points out differences and similarities between ET and CBT.

5.3.1. Master theme 1: Motivation for therapy

The findings of the first master themes concern the participants' initial motivation to do with going into therapy:

E1	C1
Varied motivation for therapy based on mental discomfort or wish for self-knowledge. Hope for well-being, self-exploration or authenticity. Expectation of capabilities and insight for self and life.	High motivation for therapy reflecting in choice of therapist based on depression, anxiety and stress or emotional burden. This related to wider life problems with hope for outcome as fixing or improvement of mental state. Expectation of learning of tools for coping.

A. Similarities

The findings suggest an overall psychological motivation for beginning therapy across the two groups. The findings also suggest that experience of mental problems or discomfort is a common reason for deciding to go into therapy. Moreover, findings indicate that participants hope for some kind of improvement through therapy and that they expect to learn some kind of capabilities in therapy.

Quite interestingly, the findings show that the choice of therapeutic approach does not have a significant role in the decision to go into therapy. Neither do associated factors like seeking information or discussion with others.

B. Differences

The findings indicate that participants from CBT are more motivated for therapy than those from ET. Almost all participants from CBT articulated having a high initial motivation for therapy, whereas the group of participants from ET articulated a mixed motivation ranging from moderate to high. It also seems that participants from CBT initially experience more mental problems than those from ET. Thus, whereas all participants from CBT based their decision on mental discomfort, around half of the participants from ET mainly based their decision on a wish for self-knowledge. Moreover, there is a minor hint that participants from CBT experiencing mental problems have slightly more tendency to pick up on them and articulate them in clinical terms from therapy. Whereas the research only provided evidence that one participant picked up on the clinical formulation from ET, the research indicated that between two and four participants picked up on a clinical formulation from CBT.

Whereas participants from ET tend to articulate their initial wishes in terms of authenticity, self-exploration and well-being, the participants from CBT articulate their initial wishes in terms of a fixing or improving of their mental state. Additionally, whereas participants from ET tend to articulate their initial expectation in terms of learning capabilities for self and life, the participants from CBT articulate their initial wishes in terms of learning tools for coping with thoughts, actions and feelings.

5.3.2. Master theme 2: Learning outcome to do with self and life

The finding of the second master theme concerns the learning outcome to do with self and life:

E2	C2
Learning authentic, valuing and caring relation to oneself with changed self-image and more insight into self and life. Engagement, satisfaction and sense of direction and values with an open and courageous approach to life and participation in the world, as opposed to previous partially problematic self-relation and self-image with lack of abilities for sensing and following values and direction in life.	Learning capabilities for capable, caring and valuing self-relation, with more positive self-image and better self-esteem. Following own values and direction in life with an open approach to life and participation in the world. In contrast with previous negative self-relation and self-image with lack of abilities for sensing and following values and direction in life.

A. Similarities

The findings show participants across the two groups experience a previous problematic self-relation and self-image with a lack of abilities for sensing and following values and direction in life.

Moreover, the findings point to a common learning outcome of a more caring and valuing self-relation with a changed self-image, a more open approach to life and participation in the world. This commonly involves a better sense of their own values and more ability to follow their own direction in life.

B. Differences

Whereas the participants from ET articulate their learning outcome to do with self in terms of a more authentic self-relation with more self-insight, the participants from CBT articulate their learning outcome to do with self in terms of a more capable self-relation with more self-esteem. Thus, the learning of authenticity and insight in ET differs from the learning of self-capability and self-esteem in CBT.

Whereas the participants from ET express their learning outcome regarding life in terms of insight into life with engagement, satisfaction and a courageous approach to life, the participants from CBT do not express their learning outcome to do with life in any additional terms.

5.3.3. Master theme 3: Learning outcome to do with thinking, acting and feeling

The third master theme concerns the learning outcome to do with thinking, acting and feeling:

E3	C3
Learning capabilities for coping with difficulties. Making genuine choices, calm way of reacting, open way of thinking. Acting from own position in life and taking own responsibility, in contrast to previous lack of capabilities to cope with difficulties and feelings. Taking responsibility and making choices.	Learning capabilities for organizing thoughts, coping with difficulties, and handling responsibility and choices, with appropriate and reflected way of acting and thinking, and a relaxed way of reacting. As opposed to a previous lack of abilities for coping with difficulties and a problematic way of thinking and acting.

A. Similarities

The findings suggest that participants across groups experience a previous lack of abilities for coping with difficulties.

Moreover, the findings suggest that participants across groups experience a common learning outcome from therapy of capabilities for coping with difficulties, making choices and taking responsibility with a relaxed way of reacting and a changed way of acting and thinking.

B. Differences

The findings indicate that participants from ET experienced a previous lack of abilities for taking responsibility and making choices, while participants from CBT experienced a previous problematic way of thinking and acting.

The findings suggest that participants from ET experienced a learning outcome of an open way of thinking and an ability to act from their own position in life, while participants from CBT experienced a learning outcome of organizing their thoughts with abilities for a reflected and appropriate way of thinking and acting. Thus, openness and positioning against the terms of organizing, appropriateness and reflexivity in thinking and acting.

5.3.4. Master theme 4: Learning to do with relationships with others

The fourth master theme concerns the learning outcome to do with relationships with others:

E4	C4

Learning capabilities for engaging in mutual relationships as oneself, with abilities to set limits and respect others. This compared to previous problematic way of relating, with a lack of capabilities for constructive engagement as oneself in mutual relationships.	Learning capabilities for being oneself as an independent person, and engaging in self-chosen mutual relationships with abilities for accepting, coping with criticism, and setting limits. Compared to previous problematic way of relating and lack of ability to be oneself in relationships.

A. Similarities

The finding of E4 and C4 point to a common experience of a previous problematic way of relating with a lack of abilities to engage as oneself in mutual relationships.

Likewise, the findings point to a common learning outcome across groups of learning capabilities for engaging as oneself in mutual relationships with relational abilities to accept others and set limits in relationships.

B. Differences

The difference in this area point to a slightly more varied learning outcome in CBT. While there are no peculiarities in the findings from ET, the findings from CBT suggest that the learning outcome in this area additionally involve becoming more capable of choosing ones relationships and separating oneself from others as an independent person.

5.3.5. Master theme 5: Perception of therapy and therapist

This finding concerns the perception of therapy and therapist:

E5	C5
Therapy as a meeting space for in-depth exploration, questioning, transformation and becoming of self. Learning for a life of courage and freedom following client's agenda. Relationship to therapist as assistant revelator and companion being with and for client.	Therapy as an educational framework for learning opening of perspectives and focusing on positive self-awareness through tools for coping with thoughts, feelings and actions. This based on specific therapeutic techniques and questioning, utilizing the relationship with the therapist as guiding teacher and friendly partner for sparring.

A. Similarities

Across groups, participants highlight the importance of the therapeutic relationship and the important role of the therapist. Thus, the learning process in therapy involves the establishment of a strong therapeutic relationship and that the therapist operates with certain relational qualities of partnership, companionship or friendship. Additionally, the therapist must operate with certain educational qualities like guiding, revealing or sparring.

Furthermore, therapeutic learning works through a process of exploring or perspectives that involve a certain dynamic of questioning.

B. Differences

Participants perceive ET as a space for in-depth exploration and transformation of self, while participants perceive CBT as an educational framework for learning that involves a self-change. Thus, the findings suggest that ET is a deeper and more comprehensive learning space than CBT, which may be more educational than ET. Furthermore, while participants perceive ET as a space to authentically become oneself, participants perceive CBT as a space for learning a positive self-awareness. Thus, transformation and authenticity against education and positive self-awareness.

Moreover, participants perceive ET as a space for learning a life of courage and freedom, whereas participants perceive CBT as a space for learning tools for coping with thoughts, feelings and actions. Hence, learning capabilities for living with freedom and courage against learning tools for coping with ones thinking, feeling and acting in life.

While participants perceive ET as a learning process following the clients' agenda, participants perceive CBT as a learning process based on specific techniques and directed by specific tools. Whereas the findings suggest that participants from ET perceive the therapist as having the role of an assistant revelator or companion, the participants from CBT perceive the therapist as having the role of a guide or teacher. Thus, in ET the therapist seems to be a companion and assistant revelator following the clients own agenda in a self-transformative learning process and in CBT the therapist seems to be a guide or teacher using specific techniques for learning specific tools in an educational self-change.

5.3.6. Master theme 6: Evaluation of learning process and outcome

The last master theme concern the participants overall evaluation of therapy:

E6	C6
Positive therapeutic relationship and choice of approach as important for intense and demanding learning process and positive learning outcome.	Importance of good therapeutic relationship, personality of therapist and effective therapeutic approach for the learning process and a positive outcome of therapy with minor disappointments.

A. Similarities

The findings indicate that participants from both groups attach a significant importance to the learning process and outcome in therapy to the choice of therapeutic approach as well as to the establishment of a good therapeutic relationship. This finding suggest that the choice of therapist is also important. Moreover, the findings indicate that participants from both groups evaluate the learning outcome as positive.

B. Differences

The findings suggest that participants from CBT may attach more importance to the personality of the therapist than participants from ET.

Unlike participants from CBT, participants from ET tend to perceive the learning process in therapy as intense and demanding.

Unlike participants from ET, participants from CBT tend to articulate minor disappointments about the process and outcome of therapy.

5.3.7. Summary of comparison

The findings suggest that there a big similarities in the experience of therapy across the groups of ET and CBT.

The findings indicate that participants are motivated for therapy and that experience of mental discomfort or problems is a common reason for the decision of going into therapy. The participants articulate a hope for improvement and expect to learn new capabilities. However, choice of therapeutic approach does not seem to be an important part of the decision for therapy.

The findings point to a previous experience of problematic self-image, self-relation and relationships with others, and a lack of abilities for following one's own values and direction in life, to cope with difficulties and engage as oneself in mutual relationships.

The findings point to a common learning outcome of better self-relation, a changed self-image, a more open approach to life with one's own direction and values and learning capabilities for reacting, coping with difficulties and making choices and taking responsibility, connected to abilities to engage in mutual relationships as oneself.

The findings suggest that establishment of a therapeutic relationship and the educational and relational role of the therapist is an important dynamic in the learning process, involving perspectives and questioning.

Participants from ET are slightly less motivated for therapy and have a certain tendency to decide on therapy out of a wish for self-knowledge. They tend to wish for authenticity and well-being whereas the participants from CBT tend to wish for fixing and mental improvement.

The participants from ET tend to experience a more varied learning outcome regarding self and life, whereas participants from CBT tend to experience a more varied learning outcome to do with relationships with others.

The participants from ET tend to experience a change in their way of acting and thinking, with more freedom and positioning, whereas the participants from CBT tend to experience a change in their way of acting and thinking with more organization, appropriateness and reflexivity.

There seems to be major differences in the participants' overall perception of therapy and therapist. While the participants from ET experience therapy as a learning space for in-depth exploring, transformation and becoming of self with capabilities for living with freedom and courage, the participants from CBT experience therapy as an educational framework for self-change with the learning of tools for coping with feelings, thoughts and behavior. Whereas the participants from ET tend to experience the therapist as having the role of a companion following the client's agenda, the participants from CBT tend to experience the therapist as a guide using specific techniques allowing them to learn tools for coping.

Chapter 6. Discussion

In this chapter, I will discuss the findings from chapter 4, especially in light of the literature review from chapter 2. I will begin with a discussion of the findings of the master themes from ET and CBT and proceed with a discussion of the comparison of master themes in ET and CBT.

Even though my research findings are based on idiographic, research into the lived experience of psychotherapy and do not attempt to represent universally objective findings. They represent a solid basis for a discussion with existing research and theoretical ideas, hypothesis and assumptions.

6.1. Discussion: Existential therapy (ET)

I this section, I will discuss the implications of the specific aspects of the findings within the six master themes from ET. So far, there has only been little research published about the process and outcome of ET, and I will mainly relate to theory (e.g. Finlay 2012; Langdridge 2013, Ch. 10). Cooper, Craig and Voss are currently working on an adequate review of the research findings of direct relevance to existential therapy (Langdridge 2013, 125).

6.1.1. Motivation for ET

This part of the discussion concerns the implications of the finding of E1 to do with the participants' motivation for going into ET.

A. Motivation and decision

Deurzen, Cohn and Spinelli more or less explicitly assume that clients' motivation for beginning therapy are based on experience of problems, distress, or discomfort in life, whereas Cohn states that clients often bring manifestations of anxiety (Spinelli 2006, 185; Deurzen 2011, 13; Cohn 2009, 69). This assumption seems to underpin the distinction between ET and existential coaching, where existential coaching is aiming at improving clients' lives from less distressed states (Spinelli 2010; Deurzen 2012). However, this simultaneously points to an overlap between existential coaching and ET, and may suggest that it is possible to widen the hypothesis about clients' motivations for beginning therapy (Deurzen 2012, xix).

The findings of E1 indicate that clients either decided on therapy from a feeling of distress and/or a wish for self-knowledge. Hence, this partially suggests a challenge to the theoretical assumptions underlying ET that distress or problems are the main motivators for going into therapy.

According to Deurzen, clients can only benefit from ET if they are able to go along with its basic assumptions, like making well-informed choices about one's own life (Deurzen 2008, 1). However, both Deurzen and Spinelli states that it is not helpful if the clients adopts the therapist's implicit assumptions through blind imitation or the therapist explains or helps reformulate the clients experiences in theoretical terms (Deurzen 2008, 2; Spinelli 2006, 122).

According to Langdridge, ET is most suitable for people who experience changes or crises in life, who wish to question their values and assumptions and are willing to engage in such work (Langdridge 2013, 46).

One basic assumption of ET is that therapy should avoid using a medico-clinical framework and rather address the clients' experiences of distress and problems in existential, relational or ethical terms (e.g. Deurzen 2008, xiii; Spinelli 2007, 69; Langdridge 2013, 47; Cooper 2012, 46). Additionally, the therapist should stay phenomenological attuned to the client's own descriptions and evaluations. Thus, du Plock describes how ET is not based on a standardized approach to the formulation of the client's problems, but seeks to capture the richness and complexity of the client's life that is not reducible to categories (Plock 1997, 6).

In the finding of E1, half of the participants articulated their initial problems in clinical terms of mental problems and/or existential terms of anxiety and stress. However, only one participant seemed to have directly picked up a diagnostic articulation of her problem from therapy. Half of the participants also or rather articulated their initial problems in terms of self-problems or lack of well-being.

In recent years, psychiatric diagnosis and classification have spread from psychiatry into everyday thinking and discourse (Rose 2006). Apart from one participant, there is no indication from the findings that the practice of ET provides clients with diagnostic and clinical understanding, and the last two participants might have picked up their clinical articulation from everyday discourse or previous therapeutic contexts. Furthermore, due to the clients varied presentation in differing terms for their basic reason for going into therapy, there is also no suggestion from the findings that ET helps the clients to formulate their decision for going into therapy in a specific way, even though exploring their decision may be part of learning in therapy.

B. Hopes, wishes and expectations

In chapter 2, I presented the educational objective of ET as the learning objective that clients undergo an existential transformation and learn capabilities to be authentic, aware of their actual existence and live with engagement, freedom and courage in accordance with their own values, beliefs and experiences.

Furthermore, Spinelli and Deurzen both articulate the facilitation of this learning as based on an exploration of the clients' personal world-views to do with their selves, others, the world/nature and (in Deurzen's case) the spiritual dimension of life (Deurzen 2008, Ch. 3; Spinelli 2007, 114-7).

Neither Spinelli nor Deurzen present an idea of problem-formulation or goal setting as an integrated part of beginning therapy. However, they both tend to articulate the importance of finding out what brought the client to therapy (Spinelli 2007, 99-101; Deurzen 2011, 128). They also both tend to articulate the importance of letting the client tell the therapist about his or her concerns and expectations regarding the process and outcome of therapy, and/or letting the therapist tell the client about what to expect from therapy. (Spinelli 2007, 100; Deurzen 2011, 129-30). According to Deurzen, clients are made aware of the importance of finding their own purpose and direction (Deurzen 2011).

Half of the participants articulate an initial wish for improvement of their well-being, closely related to a lack of well-being as their reason for going into therapy. Thus, these participants generally perceive therapy as a space for improvement of one's well-being when in a state of discomfort.

More than half of the participants articulate an initial wish for authenticity or in-depth exploration of themselves. In addition, more than half of the participants articulate an initial expectation of an outcome of insight or abilities to handle the self or life or becoming self.

These findings show how clients seem to have initial wishes and expectations for therapy and may have articulated or explored these in therapy. The findings are also interesting, because the choice of existential approach was not a recurrent theme. However, in looking back, most participants articulate their initial wishes and expectations in terms of the educational objective of ET or the theoretical design of the therapeutic learning process. These findings suggest that clients may reformulate their initial wishes and expectations of therapy in terms of their experience of the learning process and outcome of therapy. Furthermore, the findings suggests that clients may re-conceptualize their initial wishes and expectations of therapy in terms of the theoretical framework of ET. Therefore, ET may also involve a certain transference to the client of the therapists' language, and this suggests that ET may involve some kind of conceptual education of the client. These findings seem to support Deurzen's claim that clients can only benefit from ET if they are able to go along with its basic assumptions, even though in a broader sense than Deurzen seems to point out. Thus, ET involves some kind of training of the clients to be in ET and they need to adapt to the procedures and principles of ET as part of their learning process. Thereby, they must not only learn an existential attitude for self and living, but also learn an existential client attitude for exploring and discovering themselves with an existential practitioner. As the findings show, some of them might be likely to find interest in existential theory and practice as part of this learning.

6.1.2. Learning outcomes of ET

In chapter two, I formulated the educational objective of ET that clients undergo an existential transformation and learn capabilities of living more resourcefully and with higher self-awareness in relation to self, others and the world. In this section, I will mainly discuss the findings of the experienced learning outcomes of ET from E2, E3 and E4 in light of this educational objective.

As already mentioned, in Deurzen's perspective, the learning process in ET is based on an exploration of the clients' personal world-views to do with their personal, social, physical and spiritual dimension of life, involving values and ideals (Deurzen 2008, Ch. 3; Cohn 2005, 17; Adams 2013, 26). In Spinelli's perspective, it involves an exploration of the client's dispositional stances regarding the constructs labelled the self, others and the world (Spinelli 2007, 33-34, 114-7). I may articulate the educational objective of ET as learning to live in a self-chosen and resourceful way within these simultaneous dimensions.

Even though ET perceives human being as relational and embedded within three or four dimensions of Being-in-the-World, ET also involves a certain main-focus on the relational self as the center of gravity and thereby on increasing individual self-awareness (e.g. Deurzen 2011, 71; Cohn 2005, 124). This is closely connected to a focus on living human life as the core of existence and thereby on increasing the individual ability to live and meet life's challenges.

I will discuss the experienced learning outcome of ET in light of this theoretical framework.

A. Previous experiences

From a hypothetical perspective, part of ET will consists of learning focused on the educational objective, with exploration of previous and initial experiences within the different dimensions of existence.

Within the British School, Deurzen's approach describes the personal dimension of existence, involving a persons' thoughts, feelings, ideas, also the potential of authenticity and the ability to

take responsibility and make choices; the physical dimension, involving body and nature; and the spiritual dimension, involving values, beliefs and goals in life (Deurzen 2005, Part II, IV-V). Closely related, Spinelli describes the dispositional stances regarding the self-construct involving beliefs, values and assumptions together with their associated behaviors, feelings and emotions; and the world-construct, involving biological, social and cultural dimensions (Spinelli 2007, 34-5).

The finding of E2 indicated that most participants experienced a previous problematic self-relation and initial issues to do with values and direction in life. The finding of E3 indicate that participants experienced a previous lack of abilities for making choices and taking responsibility and for constructive relating to and coping with difficulties, feeling and anxiety.

These findings support the educational framework for ET as based on an exploration of the clients' existence in their personal, physical and spiritual dimension or their self- and world-constructs. What is striking at first is that participants mainly seem to articulate their previous experience in terms of lacks or difficulties. This insight may suggest that participants not only articulate their previous experience as result of the exploration but also in terms of their experienced learning outcome of therapy. This fits with the existential phenomenological insight that we tend to construct and understand our history from the position of our here-and-now (e.g. Heidegger 2009). Moreover, what is also noticeable is that previous bodily experiences were not a recurrent theme amongst the participants. This may suggest that participants actually did not have any significant previous bodily experiences. However, it may also suggest that even though ET on a theoretical level involves a rejection of the Cartesian dualism, in practice it has a problem of integrating bodily processes in therapy (Cohn 2005, Ch. 6; Madison 2012; Groth 2001). It may also suggest that some but not all existential therapists take the physical dimension very seriously,

ET emphasizes the centrality of interpersonal relations to human existence (Deurzen 2013). Part of the British school describes the social dimension of existence, involving communication and relationships (Deurzen 2005, part III). Likewise, Spinelli describes the dispositional stance regarding the other-construct, which involves relationships with other people (Spinelli 2007, 33).

The findings of E4 show that most participants experienced previous problems to do with relationships with others and lacked the ability to be themselves and engage in mutual relationships.

These findings support the theory of ET as an educational framework, which can be used for exploring and learning about relationships with others. Again, what seems interesting is that participants tend to articulate their previous experiences to do with relationships in terms of problems and lacks. This may either suggest that the initial exploration has a tendency to focus on problems or that participants interpret their previous experiences in the light of learning outcomes from therapy.

B. Learning outcome to do with self and life

The literature review suggests that the main educational objective of ET has to do with self and life as learning to live more resourcefully with self-awareness.

Deurzen and Cohn perceive selfhood as the center of one's particular world-experience (Deurzen 2005, 160; Cohn 2005, 124). Likewise, Spinelli describes how the self emerges at any time in reflection as a "temporal narrative incorporating past experience, current mood and future expectations or goals" (Spinelli 2007, 34). According to Spinelli, this self-construct is a sub-structure

of the world-view and ET involves creating a more constructive self-construct or actively choosing one's existing self-construct (Spinelli 2007, 33).

Research regarding the role of narrative in the construction of a meaningful sense of self, supports the understanding of human beings as engaged in a process of becoming (Walsh 2002, 263-4).

The existential notion of the self relates to the idea of authentic Being-in-the-world (Cohn 2005, 125; Colaizzi 2004). Cooper described authenticity and awareness of one's own existence as the common aim of existential therapies, and Colaizzi articulates authenticity as the end of existential learning (Cooper 2009, 139; Colaizzi 2004). Authenticity does not involve the idea of finding a real self but rather the idea of transforming oneself and thereby creating a confirming relationship with oneself. Therefore, authenticity points to the process of becoming oneself by affirming one's freedom and responsibility in openness. Moreover, I may describe authenticity as involving an ethical grounding of existence, because it includes choosing from a sense of one's own values and goals (Pollard 2005). Deurzen in particular highlights the importance of identifying the client's personal value system as part of ET and perceives it as the basis of a personal code of ethics (Deurzen 2011, 76).

Following Heidegger, this authentic grounding is partly mediated by conscience as the silent call to stop the individual human being from being absorbed into the anonymous and common way of being (Heidegger 2009, § 56). This call of conscience involves that I change what I care about in the world along with my way of taking care of myself in the world.

According to Walsh, research demonstrates that several aspects of authenticity, like openness to one's experience of the world, and the empowering experience of oneself as an agent, are important aspects of the process of change in successful psychotherapy (Walsh 2002, 265).

The finding of E2.10 and E2.11 showed that all participants changed their self-image and experienced learning more authenticity, self-awareness or the ability to be oneself. The finding of E2.13 showed that participants learned a better sense of their values and the ability to stand by their values. The finding of E2.14 showed that participants learned a more engaged and satisfied self. The finding of E2.16 indicated that participants experienced learning a more caring or valuing relation to themselves. These findings are important, because most participants articulated a previous experience of a problematic self-image and a lack of self-care or self-connectedness with issues to do with values in life.

These findings suggest a match between the educational objective of developing a more authentic self-relation with a better sense of personal values and the experienced learning outcome of ET. Even more than in theory, the findings suggest the significance of changing the self-image with a more valuing and caring relation to oneself. Thus, the findings seem to confirm that learning in ET involves a self-transformation with a changed perception and grounding of oneself.

Connected to the notion of authenticity, existential theory emphasizes the centrality of freedom of human existence (Spinelli 2007, 47). ET perceives freedom as closely related to the experience of uncertainty that involves anxiety (Deurzen 2008, 11; Deurzen 2011, 91; Spinelli 2007, 21-29; Cohn 2005, 70). Since ET conceives anxiety as an inevitable aspect of human existence, existential learning will contain anxiety and is not about removing it but accepting and containing it.

Deurzen also relates freedom to the possibility for clients to get a sense of purpose in their lives with the ability to set and follow their own direction in life from a sense of autonomy (Deurzen 2011, 69). According to Deurzen, this notion calls for a clarification of values and purpose in life. Deurzen

emphasizes how it also calls for the ability to live with courage, engagement and creativity in an open approach to life and its challenges (Deurzen 2008; 2011).

The findings of E2.14, E2.17 and E2.21 indicated that participants experienced a learning outcome of engagement with a more open and courageous approach to life. The finding of E2.18 and E2.22 showed that most participants learned a better sense of direction in life, with the ability to prioritize their own goals and position themselves in life. The finding of E2.19 illustrated that most participants learned to accept uncertainty, anxiety or crisis and live with freedom.

These findings match the educational objective of ET. Thus, it seems that learning capabilities for living with freedom and direction in life are actually a major learning outcome of ET, facilitated according to the educational intentions of the existential approach.

According to theory, learning capabilities for living bodily and taking part in the world are important objectives of ET (Groth 2001; Madison 2012).

The finding of E2.20 indicate that most participants learned a more desiring and engaged participation in hobbies and communities.

These finding match the educational objective of ET of taking part in the world, even though it emphasizes more the learning outcome of desiring and engaged participation. However, what is also striking about the findings is that learning capabilities for living as one's body is not an experienced learning outcome of ET. This could be because no participants experienced any bodily challenges, or that the actual practice of ET ignores bodily experiences.

Overall, the overwhelming findings in this area support the claim that learning to do with self and life is a central objective of ET and that this approach mainly focuses on self and life.

C. Learning outcome to do with thinking, acting and feeling

According to Colaizzi, existential learning involves a restructuring of one's Being-in-the-World and thereby of one's way of thinking, acting and feeling (Colaizzi 2004). ET tends to conceive thoughts, actions and emotions as interconnected aspects of a clients' Being-in-the-World. Feelings play an important role in ET. Deurzen describes how ET encourages clients to understand their feelings and use their emotions as a compass (Deurzen 2008, 126-135). Spinelli describes how the therapist might facilitate a focus on the mode of the clients' experiences involving the emotional components (Spinelli 1995, 29). As mentioned, the experience of anxiety plays a special role in ET and learning to accept and cope with anxiety as an inevitable aspect of existence itself is a source for existential learning (Cohn 2005, Ch. 7; Spinelli 2007, 27-29; Deurzen 2011, 24).

The finding of E3.4 indicated that half of the participants experienced previously lacking abilities to understand, accept or cope with feelings or problems of anxiety. The finding of E2.19 suggest that participants experienced a learning outcome of becoming more able to accept anxiety, and the findings of E3.5 and E3.7 indicated that most participants learned a calmer or more relaxed way of coping or reacting.

These findings suggest that participants experienced a learning outcome to do with accepting and coping with anxiety and becoming more able at handle their emotions. However, the findings do not necessarily point to an increased understanding of feelings even though it might be understood as an implicit part of learning related to the previous experience of lacking abilities in this area.

In general, ET emphasizes the centrality of the ability to reflect on existence for human existence, and the therapeutic exploration facilitates learning a more reflected way of thinking, acting and feeling (Deurzen 2011, 11, 73).

ET encourages clients to explore their experiences of difficulties in life and tends to see them as expression of dilemmas and tensions rather than symptoms of dysfunctions (Spinelli 2007, 68-9; Deurzen 2011, 102-4). ET does not intend to learn clients' specific capabilities for coping with difficulties. Instead, ET facilitates the client in discovering, owning and understanding meaning and insight within their life and make sense of their experience of Being-in-the-World (Spinelli 2007, 69-75). ET helps the client reflect on what these experiences mean and how they relate to difficulties in living. This may help open the client to the possibility of other perspectives, choices and actions to make. Deurzen states that ET may help the client learn personal capabilities, expertise and insight for encountering dilemmas and tensions in life (Deurzen 2011, 103).

The finding of E3.5 indicated that all participants became more capable of a relaxed or reflected way of coping with difficulties. The finding of E3.7 showed that most participants developed a calmer or reflected way of reacting. These findings were important, because most clients experienced a previous lack of abilities for coping with difficulties and had a tendency towards over-thinking, over-reacting or being over-emotional about difficulties. Furthermore, the finding of E3.9 indicated that most participants learned a more open or confident way of thinking.

These findings support the hypothesis that ET facilitates learning a more reflected way of thinking and relating to difficulties. The findings also match the educational objective of learning capabilities for handling difficulties, and even suggest that this objective may be more important than emphasized in literature on ET.

Connected to the notion of freedom, existential theory emphasizes the importance of making authentic choices and taking responsibility (Spinelli 2007, 45-51; Deurzen 2011, 69, 89; Cohn 2005, 13-4; Adams 2012, 36; Langdridge 2013, Ch. 7). According to Deurzen, this involves encouraging clients to take actions in tune with their inner motivation and sense of direction in life (Deurzen 2008, 175-185).

Research demonstrates that clients understand successful psychotherapy as involving a process of self-reflection, considering making choices and ways of acting (Walsh 2002, 263).

The findings of E3.6 and E3.10 illustrate that participants experienced becoming more capable of making genuine choices and taking their own responsibility related to previous difficulties within this area. The finding of E3.8 demonstrates that most participants experienced becoming more capable of acting from their own limits, values, awareness or maturity.

These findings not only match with the educational objective of learning capabilities for making choices and taking responsibility. They also match the theory of ET that learning to act in tune with one's own motivation and direction in life is an important part of ET. Thus, the findings indicate that ET is a very action directed approach to therapy.

D. Learning outcome to do with relationships with others

Both Deurzen and Spinelli emphasizes the centrality of inter-relations or relationships to human existence (Spinelli 2007, 12-20; Deurzen 2011, 107-13). Likewise, learning to understand and engage in relationships with others is part of the educational objective of ET. Especially, ET recognizes the

significance of inclusive or mutual relationships with others, which is partly inspired by Buber's notion of the I-Thou relationship (e.g. Spinelli 2007, 16; Deurzen 2011, 63).

The findings of E4.4 indicate that all participants experienced learning to engage in mutual or open relationships with others compared to previous difficulties within this area. These findings were significant because learning capabilities for relating was not a recurrent wish for therapy in this group of participants.

This finding supports the claim that learning to engage in relationships with others is an educational objective of ET.

According to Deurzen, an important aspect of our relatedness to others is that we want to engage with them while simultaneously need to "establish our separateness and our individuality" (Deurzen 2011, 108). In this respect, ET may both focus on helping the client to learn capabilities for engaging with others in a constructive way, and helping the client to have a mature inter-dependence from others with an appreciation of the clients' distinctiveness.

The finding of E4.5 illustrated that most participants learned to be more able to be themselves in relationships compared to previous difficulties within this area. The finding of E4.6 showed that half of the participants experienced becoming able to articulate themselves, set limits and respect others in relationships, compared to previous difficulties with relating.

These findings match the educational objective of ET to help clients with learning to engage in relationships with others. Additionally, they support the claim of ET of helping the clients with learning to engage in mutual relationships and learning capabilities for being oneself in relations and constructive ways of relating.

Overall, these findings indicate that learning to engage in relationships with others is a major learning outcome of ET, yet the least varied according to the findings.

6.1.3. Therapy in ET

In this section, I will discuss the implications of the findings of E5 and E6 regarding the perception of therapy as well as the evaluation of the learning outcome and process in ET.

In my literature review, I perceived ET as an educational framework for facilitating existential learning for the client that involves a restructuring of the client's Being-in-the-World. (Colaizzi 2004). According to Colaizzi, existential learning involves a transformation of self and life and may be a challenging and painful process. I formulated the educational objective of ET as the client's learning to live resourcefully and with self-awareness in relation to oneself, others, the world and possibly the spiritual dimension of existence. This learning objective included learning capabilities to be authentic, be aware of one's actual existence, handle difficulties and live with engagement, courage and freedom in accordance with one's true values, beliefs and experiences.

The findings of E5.1, E5.3 and E5.11 demonstrate that participants perceived therapy as an in-depth learning process about their selves that involved a transformation of their selves or transformation of their whole being. The findings of E5.5, E5.6 and E5.12 illustrate that participants perceived therapy as a learning for life with more creativity and courage in life and ability to accept uncertainty and freedom in life. The finding of E6.4 indicated that half of the participants experienced therapy as involving a difficult learning process.

These findings support the claim of perceiving ET as an educational framework for a demanding learning process that involves an in-depth exploration and transformation of self and life. In

addition, the findings show that ET has a strong focus on the client's self and life. As in theory, the findings indicate that this learning focus demands transformation and restructuring.

The finding of E2 suggests that learning about self and life is an important learning outcome of ET. Since the participants articulated an initial wish for a learning outcome to do with self and life, the findings indicate that the learning process of ET leads to the wished learning outcomes and this indication is supported by the participants' experience of a fulfilling or positive learning outcome. Interestingly, the perception of ET as involving an in-depth exploration and transformation of self and life does not necessarily support the findings of learning outcomes to do with thinking, acting and feeling and relationships with others. This discrepancy may suggest that learning about thinking, acting and feeling and relationships with others is perceived by the participants as a subordinate aspect of the in-depth exploration and transformation of self and life. The discrepancy may also suggest that the practical model of ET as an educational framework does not fully integrate these learning dimensions.

The therapist assists the client in exploring the client's existential dimensions using questioning and skills based on philosophical principles including a phenomenological method for staying with and attuning to the clients' experiences (Spinelli 1007, 114-117; Cohn 2005, 15-19; Deurzen 2011, Ch. 3). Whereas Spinelli seem to advocate a non-directive stance, according to Deurzen, this neither involves a directive or non-directive approach but rather an attempt to help the client find his or her direction (Deurzen 2011, 69).

The findings of E5.4 and E5.8 illustrated that participants experienced therapy as a client-following exploring through questioning and perspectives, testing and reflections.

These findings indicate how we must understand another part of the dynamic, which brings about learning in ET. The experience of therapy as a learning process of exploration supports the theory that ET is based on an exploration of the client's world-views. Whereas Deurzen emphasized this exploration as aiming at finding the client's direction, the participants tend to experience it as client-following, which emphasizes the explorative nature of therapy. The findings of E2 suggested that ET helps the clients find their own direction. Consequently, we might say that ET is not directive but client-following and directional.

The finding of E6.2 show that most participants experienced therapy as involving a positive or fulfilling outcome. Finally, the findings of E6.3 suggests that participants found the therapeutic approach important for their experience of therapy.

These findings support the findings of the learning outcomes as involving a substantial learning related to the participants' previous experiences of difficulties in living and their initial wishes and expectations for therapy. They also show that participants evaluate the therapeutic approach as significant for facilitating the learning they have achieved in therapy. This means that the existential approach is not random for the learning outcome experienced from ET but significant for what the participants experience as their achievement.

6.1.4. Therapist and therapeutic relationship in ET

In this section, I will discuss the implications of the findings of E5 and E6 regarding the perception of the therapist as well as the evaluation of the therapeutic relationship in ET.

In the literature review, I wrote that ET is based on the establishment of a strong therapeutic relationship between therapist and client, and Spinelli highlights this aspect the most (Spinelli 2007, 59; Cohn 2005, Ch. 5). Cohn, Spinelli and Deurzen all describe how ET takes place as a meeting in a close relationship between client and therapist that facilitates an exploration of the client's world-views. They all highlight the cooperative and mutual character this relationship must have (Cohn 2005, 33; Spinelli 2007, 59; Deurzen 2011, 63). In general, ET perceives the client as active and reflected from a sense of responsibility (Spinelli 2007; Deurzen 2011, 11). Deurzen also states, that the explorative learning process of ET involves that the client must learn how to use therapy (Deurzen 2011, 137). Research on ET confirms that a successful therapeutic experience is based on the client's perception of a humanized, substantial or authentic therapeutic relationship with an invitation to a cooperative approach (Oliviera 2012, 293).

The finding of E5.7 demonstrated that participants experienced therapy as a meeting that involved taking ownership from the client's side. Thus, therapy involves the creation of a community characterized as caring, close and non-judgmental. The client must be able to take ownership for the creation of this commonness, which is not solely the responsibility of the therapist but based on coming together. The finding of E6.1 indicate that all participants found the therapeutic relationship essential for therapy.

The findings that therapy is building on a meeting where the client takes ownership support the claim of ET as based on a mutual relationship with a focus on the client's responsibility and the client as an essential and competent part of the therapeutic process. Even more than in theory, the findings seem to emphasize the importance of the client taking ownership of learning in ET. Moreover, the findings support the claim that the therapeutic relationship is significant for the

facilitation of learning in ET. They also support the assertion that learning in ET does not work by using specific therapeutic techniques, and emphasizes questioning, perspectives, testing and reflections as means for facilitation of learning.

These findings seem essential for understanding the modelling of ET as an educational framework for a client-following and directional exploration. The dynamic of this explorative learning works through a meeting between therapist and client where the client takes ownership for learning and a strong therapeutic relationship is established between client and therapist.

Deurzen articulates the role of the therapist in terms of an experienced teacher who can stimulate and channel original growth of the client (Deurzen 2008, 21). However, the therapist is not directive but rather assists clients in the process of living with greater expertise and thereby encourages and helps the client (Deurzen 2008, 19). The therapist does not provide a pre-fabricated framework of meaning or specific skills, but enters a mutual dialogue with the client and works by being with the client (Deurzen 2008, 20; Deurzen 2011, 30-31, 63). It may therefore be more useful to describe the therapist as a mentor rather than a teacher (Deurzen 2008, 20).

Cohn articulates the function of the therapist in terms like helping, assisting, enabling, listening and providing from an informed, personal and real role (Cohn 2005, 24, 27, 37, and 124). The therapist works from an existential and phenomenological position that helps explore and clarify the client's experience in a mutual relationship (Cohn 2005, 15-1933).

Spinelli highlights that the therapist must work through presence, acceptance and immediacy with a dialogical attitude from a phenomenological position of un-knowing (Spinelli 2007, 59-64). The

therapist must be non-judgmental and attempt to attune to the client by being with and for the client (Spinelli 2007, 108-113).

Research on ET shows that for clients, a successful therapeutic experience is based on the perception of a knowing, competent or power-invested therapist with a non-judgmental attitude who has the ability to validate the client's experience (Oliviera 2012, 293).

The findings of E5.2 illustrates that all participants perceived the therapist in the function of being or talking with the client. The findings of E5.9 demonstrate how all participants experienced the therapist in the role of an aware partner or companion. This partner or companion works through qualities of being knowing, aware or engaged. The finding of E5.10 indicated that half of the participants perceived the therapist as a midwife or revelator. This revelator works through the qualities of recognizing, assisting or supporting.

These findings support the claim that part of the dynamic of learning in ET is that the therapist works through being with and/or for the client. Furthermore, the findings support the assertion that the therapist's educational role is not one of an advisor or a directive teacher and suggest the term companion for part of the educational role. Thus, the therapist accompanies the client in an in-depth learning and transformation of self and life. This term supports the idea of the therapist following the client's agenda and inviting the client to cooperate as an essential and competent part of the therapeutic process. For the participants, the perception of successful therapeutic experience seems to be based on the experience of the therapist as knowing, aware or engaged and this supports previous research findings on the competent and knowing therapist and might slightly challenge or call for a modification of Spinelli's ideal of the unknowing therapist.

The findings also suggest the term assistant and recognizing revelator, which support the assertion that therapist is assisting the client in the learning process. According to the findings, I may conceive the in-depth and explorative learning in ET facilitated by the therapist as a revelation that opens and unfolds new possibilities for the client. The therapist's recognition of the client seems to be significant for this revelation to progress. This corresponds to previous research findings that it is important that the therapist is able to validate the client's experience and has a non-judgmental attitude (Oliviera 2012, 296-7). Honneth describes how recognition in relationships gives the individual confidence to develop identity and self-confidence (Honneth 1996). Likewise, by recognizing the client, the therapist gives the client the experience of being approached as a human being, which gives the client confidence in expressing and elaborating his or her own experience and thereby developing identity and self-confidence.

6.2. Discussion of findings from CBT

I this section, I will discuss the implications of the specific aspects of the findings within the six master themes from CBT.

6.2.1. Motivation for CBT

This part of the discussion concerns the implications of the findings of C1 to do with the participants' motivation for going into CBT.

A. Motivation and decision

According to Wills, CBT may include an assessment of the client's motivation for therapy in order to secure suitability and commitment for CBT (Wills 2008, 19). Thus, Wills perceives commitment for CBT as essential for the outcome of CBT. Furthermore, Wills describes how clients are suitable for CBT if they have good access to their thoughts; accept a structured approach and responsibility for change; can undertake homework; and settle into a CBT therapeutic relationship.

The finding of C1.1 illustrate that participants had a high psychological motivation for starting in CBT, which underlines the significance of commitment for this approach. The findings of C1.5 show that half of the participants based their decision to go into therapy on a reflected choice of therapist, which suggest that the participants' are dedicated to therapy.

CBT is based on the medical or psychiatric model and on the identification of symptoms to diagnose a mental disorder and produce treatment aimed at reducing pathological symptoms (Hawton 2009). CBT tend to articulate mental problems as the main motivator for beginning therapy and overall CBT is a method designed for assessment and treatment of mental disorders. The beginning of CBT involves assessment and problem formulation, which has a tendency to focus on client's presenting issues and mental problems related to certain life situations and problems (Wills 2008, Ch. 2). Problem formulation in CBT relies on a collaboration between therapist and client. The client brings his or her knowledge about the presenting issue. The therapist brings clinical conceptualization of the problem as well as disorder-specific models and treatments (Dudley 2014). The therapist may employ the strategy of psycho-education to educate the client about the rationality and procedures of CBT as well as about the clients' clinical problem and its perpetuating factors, e.g. anxiety and

avoidance (Leahy 2004). Thus, in CBT the client must learn to identify and formulate his or her problems in clinical terms as part of therapy.

Quantitative research demonstrates that CBT is an efficient approach for identification and treatment of specific mental disorders like depression, panic anxiety, general anxiety disorder and stress (Mitte 2005; Covin 2008; Richardson 2008).

The finding of C1.2 illustrates that most participants based their decision on a mental problem of anxiety, stress or depression and there was a minor indication that they had picked up the clinical conceptualization from therapy. The finding of C1.3 showed that half of the participants experienced emotional problems and the finding of C1.4 demonstrated that most participants based their decision on the experience of a concrete problem at work, or in their life or relationship.

These findings support the assertion that the main reason for beginning CBT is the experience of mental or emotional problems related to life problems and situations. The findings also suggest support for the claim that CBT involves a collaborative and educational reformulation of the client's experiences in clinical terms. Interestingly, not all participants articulated their experiences in clinical terms and this may suggest that clinical problem formulation and psycho-education are not necessary or decisive aspects of learning in CBT.

The beginning of CBT involves agenda- and goal-setting that also relies on a collaboration between therapist and client. The client brings his or her hopes and wishes and the therapist brings clinical models, procedures and measurements (Hawton 2009, 41). Hence, the therapist and the client agree on specific goals for each of the problem areas that they are going to work on.

The findings of C1.6 and C1.8 show that most participants articulated an initial hope for improvement of their mental state and/or a fixing of their problems or normalization. Furthermore, the finding of C1.7 showed that most participants expected a learning of tools or abilities for coping with anxiety, problems or thoughts.

These findings do not only suggest that participants initially wished for an improvement of their mental state and a handling of their problems related to their reason for going into therapy. The findings also suggest that clients tend to reformulate their initial wishes and expectations for therapy in light of the collaborative formulation of problems and goals for therapy as well as the education on clinical procedures in CBT. This suggestion is supported by the circumstance that choice of CBT was not a recurrent theme to do with the decision of therapy amongst the participants. Thus, CBT seems to include some conceptual education of the clients regarding their formulation of initial wishes and expectations for therapy.

6.2.2. Learning outcomes in CBT

In the literature review, I formulated that the educational objective of CBT is to help clients change the way they think, feel and behave so that they can think, feel and behave in more adaptive ways in response to given situations and events. Thus, the aim is that clients unlearn maladaptive skills, strategies and patterns of thinking, feeling and behaving and learn adaptive cognitive and behavioural skills and strategies for coping with a more positive sense of self and an ability to succeed in life. In this section, I will mainly discuss the findings of the experienced learning outcomes of CBT from C2, C3 and C4 in light of this educational objective.

Facilitation of learning in CBT begins with assessment, problem formulation and agenda setting that involves accessing the client's maladaptive patterns, arriving at a diagnosis, and developing a formulation of the problem and goals for therapy (Wills 2008). The therapist may employ psycho-education to educate the client about the rationality and procedures of CBT and the client's problem (Leahy 2004). Next, learning in CBT involves educating the client in identifying previously learned maladaptive patterns for learning more adaptive thinking and coping strategies through a wide range of specific therapeutic techniques. The basic hypothesis of CBT is that behaviours and emotions are determined by the client's thoughts and perceptions of situations and the therapist must help the client to learn the connection between their thought processes, emotional responses, subsequent behavior and physical symptoms (Wills 2008; Leahy 2004). This involves learning to challenge the client's schemas or core beliefs about the self, others and the world and his or her subsequent assumptions or rules for living at large (Wills 2008, 27). CBT does not only focus on educational correction of faulty patterns and strategies of thoughts, behavior and emotions but also on developing a new resilient sense of self and adaptive perspectives on life and situations.

I will discuss the experienced learning outcome of CBT in light of this theoretical framework.

A. Previous experiences

From a hypothetical perspective, part of CBT consists of learning, focused on the educational objective, with identification and conceptualization of problematic initial situations and ways of responding.

Part of the problem formulation in CBT consists of helping the client to make explicit potential causes for his or her difficulties in living. This includes identifying events and situations in life that trigger problems and activate the client's maladaptive beliefs about the self, others and the world, and subsequent maladaptive assumptions or rules for living (Wills 2008, 27). According to the five-area model, maladaptive patterns are also maintained by dysfunctional life strategies and behavior that are to be identified in therapy (Padesky 1995). According to Wills, these assumptions, rules, behaviors and strategies are compensation devices that help people to cope with their negative or maladaptive core beliefs (Wills 2008, 130).

CBT emphasizes how individuals develop negative or maladaptive beliefs about themselves. These beliefs are activated by stressful life-events and may involve a negative self-image, with negative self-evaluations, self-punishment, low self-regard or negative self-esteem (Wills 2008, 134-6; Trower 2010, 63, 129, 135, 138). Part of CBT will consist of identifying these self-beliefs and self-schemas.

The findings of C2.1 and C2.3 illustrate that most participants previously had a negative self-image with a low self-esteem or self-regard. The findings of C2.2 demonstrate how participants initially lacked ability to sense or follow their values or have control or direction in life.

These findings support the claim that CBT involves an educational focus on identifying difficulties in living and negative self-beliefs and assumptions and rules for living. The findings do not seem to point directly to identification of dysfunctional beliefs about the world, yet even more than in theory, they stress the significance of initial issues to do with values and direction in life.

CBT involves an educational focus on identifying negative patterns and strategies of thoughts, behaviour, and negative emotional responses that are activated by difficult situations and events (Wills 2008, 28). This involves identifying maladaptive strategies for coping with difficulties and mental disorders.

The findings of C3.1 and C3.2 indicate that participants previously experienced lacking abilities for understanding and coping with difficulties, feelings and anxiety and anxious situations. The findings of C3.3 and C3.4 show that participants variously articulated experiences of a previous inappropriate pattern of thinking or acting and/or lacked the ability to understand and organize their thoughts and behavior.

These findings support the idea that CBT involves an initial identification of negative patterns and strategies of thinking and acting as well as maladaptive strategies for coping with difficulties, emotional responses and/or mental disorders.

Wills highlights that CBT includes an educational focus on identifying negative beliefs about others and negative patterns and strategies of social interaction (Wills 2008, Ch. 3). Especially, recent developments within CBT perceive relational factors and the social environment as important factors for the development and maintenance of mental problems.

The findings of C4.1, C4.2, C4.3 and C4.4 illustrate that most participants point to a previous problematic way of relating to others and a lack of ability to be themselves in relationships.

These findings support the assertion that CBT involves an initial identification of negative beliefs of others and negative relational patterns and strategies and emphasize the significance of this part of CBT.

Overall, the findings about previous experiences suggest that participants learn to identify and conceptualize their past and initial experiences in terms of the educational framework of CBT.

B. Learning outcome to do with self and life

According to Hickes and Mirea, the main objective of CBT is to ensure the client's success and happiness in life by changing the client's assumptions, rules and strategies for living (Hickes 2008, 22). This involves exploration and unlearning of maladaptive assumptions, values and strategies for living, clarification of values and the learning of more rational and appropriate assumptions, rules and strategies for living.

The findings of C2.7 and C2.9 showed that part most participants articulated learning a more open approach to life with the ability to follow one's own direction in life. The finding of E2.10 suggest that most participants experienced becoming more capable of engaging in communities and hobbies.

These findings do not only support the claim that CBT involves an educational objective of teaching the client a more appropriate way by which the client may live his or her life. More than in theory, the findings highlight a significant learning outcome of CBT to do with becoming more open and engaged in life with the ability to follow one's own interests and direction in life.

Beck stresses that an important aspect of CT may be to identify negative or inaccurate self-beliefs and remove symptoms of intense self-consciousness and self-attention-binding as well as negative representations of the self with low self-evaluation and self-criticism (Beck 1991, 79; Beck 2009, 22,

25, 349). The educational objective in this respect is to learn a more appropriate self-concept. Additionally, Hickes and Mirea point out that for the clients, part of the educational objective of CBT involves learning a better sense of their selves and themselves (Hickes 2012, 22). Likewise, Wills and Trower describe how CBT involves changing the negative self-image and negative self-schema and learning self-efficacy with more positive self-evaluation and self-perception (Wills 2008; Trower 2010). Furthermore, more specifically authors such as Fenell and Treasure highlight how CBT may help clients target and improve their self-esteem or ability for self-care (Treasure 1996; Fenell 2005).

The finding of E2.4, E2.5 and E2.8 illustrate that all participants changed their self-image and experienced becoming more capable of self-care, self-structure or self-awareness and having a better self-esteem.

These findings underline the assertion that CBT involves an important learning outcome to do with the clients self and self-awareness. Even more than in theory, the findings suggest that learning abilities for self-care, self-structure and improving self-esteem is not only a significant but general learning outcome of CBT. This is interesting, because most literature on CBT tend to underestimate self-care and self-esteem as important aspects of the educational objective of CBT.

C. Learning outcome to do with thinking, acting and feeling

The basic principle of CBT is that emotions and behaviours are connected to the client's thoughts and perceptions of situations encountered. Therefore, the therapist must help the client understand the connection between their thought processes, emotional responses and behaviour. Thus, learning to do with thinking, acting and feeling is at the core of the educational objective of CBT.

This learning focuses on identifying and evaluating emotions; identifying and challenging negative patterns of thinking for more realistic, rational and balanced thinking with the ability of organizing the thoughts; and analyzing problematic behavior for more appropriate behavior with the ability for self-monitoring behavior (Padesky 1995; Wills 2008). Reflection is highly important to CBT and is implicit in all these aspects of the educational objective of CBT.

The findings of C3.6 illustrate that most participants learned a more capable way of thinking or became more capable of organizing their thoughts. The findings of C3.7 show that most participants became capable of behaving and acting in a reflected way.

These findings support the claim that learning balanced thinking and appropriate behavior in a reflected way is a major learning outcome of CBT. Interestingly, learning to understand emotions and feelings was not a recurrent learning outcome amongst the participants. This might suggest that participants experience emotional learning as implicit in their achievements related to previous difficulties to do with feelings and anxiety.

Part of CBT consists of building an understanding of the difficulties faced in the client's life. This means helping the client to make explicit potential causes for their difficulties in living and identifying situations and events that trigger maladaptive patterns of thoughts, actions and feelings including maladaptive rules for living and coping strategies (Padesky 1995, Ch. 5; Wills 2008, 28). The educational objective is to change the dysfunctional perception of critical situations and events and to learn new, or strengthen existing, coping strategies (Wills 2008, 98). For instance, this objective may involve strengthening assertiveness capabilities, using visualization and learning to relax. According to Rosenberg, problem-solving and coping is one of the three main strategies of

CBT and this strategy has a main focus on analysis of situation and restructuring of thinking (Rosenberg 2007, 244).

The psycho-educational strategy of CBT may involve that the client learns to understand the cognitive-behavioural dynamic of specific mental disorders like anxiety or depression. This is connected to learning specific techniques for handling these disorders (Padesky 1995, Ch. 10-12).

The findings of C3.5 demonstrate that most participants articulated becoming more capable of solving problems and coping with difficulties and anxiety as compared to a previous lack of these capabilities. The findings of C3.9 suggest that most participants became more capable of reacting in a reflected, resistant or relaxed way.

These findings underline the educational objective of CBT to do with understanding and coping with difficulties as well as reacting in a reflected or relaxed way. Thus, learning to react and cope with difficulties is a significant learning outcome of CBT.

According to Wills, facilitation of learning in CBT emphasizes the client's responsibility for and control of change (Wills 2008, 13). According to Rosenberg, CBT takes inspiration from the existential approach in its concern for the client's ability to make choices and plan his or her existence (Rosenberg 2007, 247). The abilities of taking responsibility and making choices are immanent aspects of the highly rationalistic perspective of the human being in CBT. However, even though the ability to make choices and take responsibility may be parts of CBT, they mainly constitute implicit dimensions of the theoretical framework and are seldom discussed in their own right.

The findings of C3.8 show that most participants became more capable of taking responsibility and making choices. These findings not only match the hypothetical assertion to do with responsibility and choices but also suggest that this is an important experienced learning outcome of CBT not properly explored in the literature.

C. Learning outcome to do with relationships with others

CBT recognizes the significance of interpersonal learning and relational factors for the development of mental problems (Wills 2008, 35). CBT may involve identification of critical events and situations in the social environment, exploration of the significance of early relational experiences and the formation of dysfunctional beliefs and assumptions about others as well as maladaptive strategies for interaction with others. Recent developments within CBT involve the integration of attachment theory and focus on patterns in relationships (e.g. Young 2006). More generally, the educational objective of CBT will involve interpersonal learning with a focus on analysis of interpersonal problems and a restructuring of problematic thinking. This may involve behavioural methods for modifying maladaptive thinking like interpersonal problem-solving training and social skills training (Trower 2010, 93-5).

The findings of C4.5 illustrate that half of the participants articulated themselves as social persons, which emphasizes the significance of the interpersonal dimension. The finding of C4.7 and C4.8 showed that most participants experienced learning to engage in mutual relationships and/or capabilities for constructive relating to others. The finding of C4.6 and C4.9 demonstrated that most participants experienced becoming more capable of being themselves in relationships and/or being independent in relationships with others.

These findings not only underpin recent theories of CBT that underline interpersonal learning as an important aspect of the educational objective of CBT. Even more than in theory, the findings suggest that learning to do with relationships with others is one of the most significant learning outcomes of CBT. This relates to participants' common experience of relational difficulties and widespread experience of being social persons. It shows that interpersonal learning is a major focus in the practice of CBT not fully accounted for in the theory and might suggest that the therapeutic focus on participants' difficulties in self and life, and thinking and acting should be related to a focus on interpersonal issues.

Overall, the findings of the participants' experiences of previous difficulties to do with self and life, thinking, acting and feeling and relationships with others match the findings of the participants experienced learning outcomes. This match may suggest that participants tend to articulate their previous experiences in light of their learning outcome within these three major areas.

6.2.3. Therapy in CBT

In this section, I will discuss the implications of the findings of C5 and C6 regarding the perception of therapy as well as the evaluation of the learning outcome and process in CBT.

CBT may be articulated as an explicit educational framework for cognitive and behavioural learning for the client. The first step in CBT consists of educational assessment and a formulation of the client's maladaptive thoughts and actions and emotional responses. This Includes identifying the client's learned maladaptive beliefs about self, others, the world and/or the future and the client's dysfunctional assumptions and rules for living and inappropriate strategies for coping and living (e.g. Wills 2008; Trower 2010; Padesky 1995; Hawton 2009). The first step of CBT makes up the

foundation for the educational objective of changing maladaptive patterns and learn in more adaptive ways of thinking, acting and feeling with a better sense of self and ability to succeed in living.

The findings of C5.1 indicate that all participants perceived CBT as an educational framework for learning or self-change. The finding of C6.3 indicated that most participants evaluated CBT as having the positive outcome of improving their mental state, allowing them to handle their relationship or giving them tools for coping with anxiety. The finding of C6.4 suggested that half of the participants articulated minor disappointments to do with the therapeutic process or outcome. Because of its being less concrete than expected or progressing too slowly.

These findings support the idea of conceptualizing CBT as an educational framework for learning. The findings also indicate that the experience of self-change may be an important aspect of this learning and perhaps is even more significant than suggested in the literature. The findings indicate that participants experienced a positive learning outcome to do with self/life, coping and relations, matching the findings of the three major learning outcomes of CBT. This match suggest that participants experience a fulfilling of their initial wishes and expectations. The match may also suggest that participants have learned to formulate their experiences in light of the experienced learning outcome of CBT as well as the educational objective and theoretical and conceptual framework of CBT.

The next step in CBT is a facilitation of learning for the client by instructing the client in more adaptive ways of thinking, acting and feeling (Clark 2009; Leahy 2004; Wills 2008; Trower 2010; Padesky 1995; Hawton 2009). This step involves changing maladaptive beliefs about self, others and the world or the future and challenging maladaptive assumptions and rules for living. This step also

involves teaching or instructing the client in more constructive coping strategies. In order to facilitate this learning, the therapist employs a wide range of specific therapeutic techniques. These might include verbal techniques; imaginary techniques; and behavioural techniques (Wills 2008; Leahy 2004; Trower 2010; Padesky 1995; Hawton 2009; Clark 2009). Hickes and Mirea articulate this learning as a clarification of behaviours, thoughts, emotions, core beliefs and values aimed at developing a new sense of self by opening different perspectives and choices for the client (Hickes 2012, 25).

Some research suggests that cognitive and behavioural techniques lead to positive outcomes against dysfunctional thinking and acting, whereas other research questions the use of cognitive techniques (Cooper 2008, 134).

The findings of C5.4 indicate that most participants experienced therapy as an exchange or opening of perspectives of self, life or ways of acting. The findings of C5.5 illustrate that most participants experienced therapy as focusing on increasing self-care, self-esteem or positive self-awareness. The finding of C5.2 showed that most participants perceived therapy as a learning of tools for coping with anxiety or organizing thoughts or behavior. The findings of C5.3 demonstrate that most participants perceived therapy to be based on specific therapeutic techniques. Finally, the findings of E6.3 illustrate that most participants evaluated therapy or the therapeutic approach as significant for their experience of the learning process and outcome of therapy.

These findings give an indication to how we must understand the experienced learning process involved in CBT. They suggests four components of the dynamic that brings this learning process about: An opening or exchange of perspectives on the self, life and ways of acting and a focusing on

positive self-awareness; self-care; and self-esteem, which is directed at learning tools for coping and based on specific therapeutic techniques

These finding seem to support research saying that therapeutic techniques are essential for clients' therapeutic experience.

The findings support the theoretical assumptions about the educational framework of CBT. Even more than in theory, they seem to highlight the significance of the therapeutic focus on self-care, self-esteem and positive self-awareness. The match between theory and findings indicate that the way in which participants report the outcome, match the theory of CBT. This might indicate that CBT works according to its theoretical design and that participants are able to conceptualize their experiences of the dynamic in CBT according to the procedures of CBT. It might also suggest that the clients pick up the vocabulary from the therapist and learn to adapt to the procedures and principles of CBT as part of being clients in CBT. Thus, this match might support the assertion that CBT includes some kind of education of the client in the method and procedures of CBT. This seem to underline their evaluation of therapy or the therapeutic approach as important for their experienced learning process and outcome. Thus, participants experience the approach of CBT as significant for the outcome of CBT and this suggests that therapeutic approach is not random but central for the learners' specific achievements from CBT.

Overall, the findings of C5 and C6 strongly support the idea of perceiving CBT as an educational framework for learning and self-change that works through the dynamic of opening perspectives and focusing positively on the self. This learning is directed at learning tools for coping and based on the use of specific therapeutic techniques.

6.2.4. Therapist and therapeutic relationship in CBT

In this section, I will discuss the implications of the findings of C5 and C6 regarding the perception of the therapist as well as the evaluation of the therapeutic relationship in CBT.

The educational design of CBT is based on the establishment of a strong therapeutic relationship between therapist and client (Wills 2008, Ch. 3). Whereas early theories of CT and CBT were criticized for not giving sufficient emphasis on this relationship, recent theories highlight the interpersonal dynamic between client and therapist as important for the facilitation of learning in CBT.

The findings of E6.1 suggest that most participants articulated experiences of the importance of the therapeutic relationship. Thus, participants value the relationship with the therapist as beneficial or important for their experience of learning in therapy.

These findings support recent tendencies within CBT to stress the significance of the therapeutic relationship.

The theories of CBT tend to perceive the role and function of the therapist in educational terms. According to Wills, this educational role involves a didactic aspect where the therapist gives the client instructions and information (Wills 2008, 11). However, according to Wills, the educational role also involves a tutorial dimension, where the therapeutic relationship is closer to a tutor-coach relationship and the function of the therapist is to help the client to learn by fostering reflection and activity (Wills 2008, 12). Initially, the therapist will tend to take responsibility and control but

gradually the therapeutic relationship will evolve towards a consultative mode and responsibility with control handed over to the client (Wills 2008, 9). Following Beck, the therapeutic relationship in CT and CBT is characterized by empathy, warmth and genuineness (Beck 1979, 21).

The findings of C5.6 indicate that most participants experienced the therapist as a guide, teacher or sparring partner. Furthermore, for these participants, a successful therapeutic experience seems to be based on perception of the therapist as friendly, empathic or reassuring.

These findings do not only match the theory of CBT and its tendency to perceive the therapist in the educational roles of teacher, coach and consultant. They also match the emphasis on the therapists' ability to work through relational qualities like empathy and genuineness. Along with the evaluation of the importance of the therapeutic relationship, this match suggest that the educational role of the therapist is essential for the educational dynamic in CBT.

Overall, the findings of C5 and C6 give strong support to the idea of perceiving CBT as based on the establishment of a strong therapeutic relationship between client and therapist, who takes on the educational roles of teacher, guide or partner and works through empathy and friendliness.

6.3. Discussion of comparison

In this section, I will discuss the implications of the findings, comparing master-themes in the two groups. I will partly conduct this discussion in light of the theoretical comparison of ET and CBT from my literature review and the previous discussions of the findings in the two groups.

6.3.1. Motivation for psychotherapy

A. Psychological motivation and decision

Literature has suggested that clients' psychological motivation for psychotherapy and change is a major factor for successful process and outcome of psychotherapy and issues around referral matter to the clients' motivation (e.g. Schweickhardt 2009; Carey 2007). Deurzen and Wills state that clients are only suitable for ET and CBT and can only benefit from therapy if they are able to go along with their basic assumptions and procedures (Deurzen 2008, 1; Wills 2008, 19). Furthermore, Wills suggests that commitment to CBT is an important factor for the process and outcome of therapy.

The findings of E1 and C1 suggest an overall psychological motivation for beginning therapy across the two groups. However, the findings also indicate that participants from CBT were slightly more motivated for therapy. Since my research only looks at people who had made a voluntary choice to go into therapy and did not initially drop out of therapy, the findings support the claim that psychological motivation matters to the process and outcome of therapy. The difference in motivation between the two groups may be coincidental or it may suggest that the educational design of CBT involves a stronger focus on committing the clients.

Importantly, the findings showed that choice of therapeutic approach was not a recurrent theme in any of the groups and this might suggests that participants made a passive or uninformed choice. It might also suggest that choice of therapist is based on more unconscious, emotional or subliminal aspects. In either way, it suggest that people going into therapy are not fully aware or reflected about what and how they are going to learn in therapy, and this might simply be because they have not learned it yet but expect to learn it in therapy and actually will not learn it before they have started in therapy.

Most literature on psychotherapy involves the assumption that clients base their decision of going into therapy on an experience of some kind of distress (e.g. Barker 2010, 9). This basic assumption is reflected in the literature on CBT and ET and both approaches tend to understand client's experience of distress as related to difficulties in living (Hickes 2012, 25). However, CBT bases itself on the psychiatric model and on the identification of symptoms to diagnose a mental disorder involving a collaborative formulation of the client's problem in clinical and educational terms (Hickes 2012, 24; Dudley 2014), whereas ET rejects the psychiatric model, and from an existential phenomenological perspective seeks to understand the client's experience of distress and relate it to an ethical or existential understanding of problems to do with dilemmas (Deurzen 2008, xiii; Spinelli 2007, 69).

The findings show that most participants across the two groups based their decision to go into therapy on the experience of mental distress and/or problems. The findings also illustrated that many participants articulated this experience in clinical terms, yet there was a slightly bigger tendency for participants to pick up this articulation from CBT. However, the findings showed that around half of the participants from ET based their decision of therapy on a wish for self-knowledge, which seems interesting because choice of therapeutic approach was not a recurrent theme. This might suggest that participants from CBT experience more mental problems. It might also suggest that participants tend to articulate their initial decision of therapy in light of their experience of learning in therapy and that ET involves more focus on personal growth and less focus on mental distress than CBT. Finally, the difference might suggest that clients choose on a more emotional or unconscious level, and that there is something about the therapist or therapeutic approach that resonates with the clients initial desire but not in a fully conscious or reflected way.

B. Hopes, wishes and expectations for therapy

Most literature on psychotherapy is based on the assumption that the objective of psychotherapy is that clients make some kind of change or find ways to understand or cope with their situation (e.g. Barker 2010, 9). I have argued for the possibility of formulating the objective of ET and CBT in educational terms as learning for the client that involves some kind of change of self and life. However, I have argued that the main educational objective of ET is that clients learn capabilities to live resourcefully with awareness in relation to self, others and the world. On the other hand, I have argued that the main educational objective of CBT is that clients learn capabilities for successful living and a positive sense of self with adaptive thinking, acting and feeling and appropriate coping.

Both approaches involves an initial focus on the client's initial wishes and expectations for therapy and on letting the therapist tell the client about what to expect from therapy (Wills 2008, Ch. 2; Spinelli 2007, 99-101; Deurzen 2011, 12-30). However, whereas ET intends to begin with a co-creation of the therapeutic world and hold a focus on the client's agenda, CBT involves a collaborative goal-setting and lets the therapist set the overall agenda (Spinelli 2007, Ch. 5; Wills 2008, 30-31).

Research shows how clients' hopes for the therapeutic process and expectations for outcome relate to outcome. Part of the variance in therapeutic outcomes can be accounted for by clients' beliefs (Cooper 2008, 63-4). Research also shows that if clients are educated about the goals and nature of therapy, it reduces the dropout rate and gives them realistic expectations for therapy and more outcome from therapy (Cooper 2008, 65).

The comparison of the findings of E1 and C2 illustrates that most participants across the two groups articulated an initial hope for improvement from therapy and expected to learn some kind of capabilities. This common finding might relate to the finding in E6 and C6 of a positive evaluation of therapy. However, participants from ET tend to articulate their initial wishes in terms of authenticity and self-exploration with expectation of learning capabilities for self and life, whereas participants from CBT articulate their initial wishes in terms of fixing or improving their mental state with expectations of learning tools for coping with thoughts, actions and feelings. These findings suggest that participants tend to articulate their initial wishes and expectation for therapy according to the general conceptualization of psychotherapy. Because choice of therapeutic approach was not a recurrent theme, the difference between the two groups suggests that participants learn to formulate or reformulate their initial wishes and expectations to therapy as part of their learning in therapy and according to the basic theoretical assumptions in the two approaches. This might suggest that therapy is more directive than it intends to be. Especially, to some degree, it challenges the assumption in ET that therapy must avoid directing the client according to the agenda of the therapist.

6.3.2. Learning outcomes in psychotherapy

Whereas educational objectives regard the intentions of the educator, learning outcome are concerned with the achievements of the learner (Moon 2002; Adam 2004).

The phenomenological approach involves an analysis of the outcome of the learning process in qualitative terms (Broberg 2000, 43). Learning involves a change in the understanding of phenomena, and it is possible to identify qualitative differences in the understanding of

phenomena, that is, in the subjective comprehension and attitude to phenomena. Consequently, I can define and judge understanding by its quality.

As I wrote in my literature review, Burnett categorized participants' responses to counselling in terms of three broad areas of learning: Self, Relation with others, and the Process of learning and change (Burnett 2000). According to Carey, participants described experiencing change in three domains: feelings, thoughts and actions (Carey 2007).

The literature review suggested the CBT and ET share an educational focus on clients' interpretation of their self, others and the world and shared educational objectives of learning to do with perspectives on self, others and the world with capabilities for emotions, values and direction in living and handling difficulties in life (e.g. Hickes 2012, 25-7).

Interestingly, the findings of E2-4 and C2-4 suggest an overall common structure for the experienced learning outcome of ET and CBT: Learning to do with self and life; thinking, acting and feeling; and relations to others. The findings of this structure relatively seem to combine the results from Burnett and Carey. Furthermore, it partly matches the theoretical comparison of the educational focus in ET and CBT.

Surprisingly, the details of the findings of E2-4 and C2-4 suggest a high level of qualitative similarity between the experienced learning outcome of ET and CBT. Thus, one shared learning outcome is learning a caring and valued self-relation with a changed self-image and capabilities for following values and direction in life. Secondly, learning capabilities for coping with difficulties and reacting in a relaxed way with a changed way of acting, thinking and learning to make choices and take

responsibility. Thirdly, learning to engage as oneself in mutual relationships with abilities to accept others and set limits in relationships.

However, the comparison also suggests that the learning outcome of ET centers on learning authenticity and positioning in life, whereas the learning outcome of CBT centers on learning functional capabilities for an appropriate and structured way of thinking, acting and feeling. This qualitative difference might be essential, as it seems to point to learning a way of personal positioning and free self-determination with an open way of thinking, acting and feeling as opposed to learning a socially adapted position in life with socially appropriate self-determination and an instrumental way of thinking, acting and feeling.

A. Previous experiences

From a hypothetical perspective, part of both CBT and ET consists of learning focused on the exploration or identification of the client's previous and initial experiences to do with difficulties in living (Wills 2008; Trower 2010; Cohn 2005; Deurzen 2011; Spinelli 2007). Literature suggest a common educational focus on clients' interpretation of their self, others and the world and their emotions, beliefs and values for living (Hickes 2012).

The comparison of E2 and C2 shows that participants previously shared a problematic self-image and self–relation and lacked abilities for following values and direction in life. The comparison of E3 and C3 indicates that participants shared a previous lack of abilities for coping with difficulties. The comparison of E4 and C4 illustrates a common experience of a previous problematic way of relating with lack of abilities to engage as oneself in mutual relationships.

1. Firstly, these finding may suggest some kind of common experience for people beginning psychotherapy to do with difficulties in life regarding self, values, direction, relationships and coping. Above all, I find support for this from the high degree of similarity between the two groups. This may involve that people who decide to go into therapy share some basic experiences of difficulties in the initial way by which they live their lives.

2. Secondly, the findings may also suggest that CBT and ET involve a common learning for people beginning psychotherapy that involves addressing initial and previous experiences in terms of difficulties. I find support for this from the circumstance that participants overall tended to articulate their previous or initial experiences in terms of difficulties. Furthermore, I find support for this from the circumstance that the shared articulation of previous or initial experiences tend to match the shared educational focus in ET and CBT.

The comparison of E3 and C3 also indicates that participants from ET experienced a previous lack of abilities for taking responsibility and making choices, while participants from CBT experienced a problematic way of thinking and acting. This difference seems to match a difference in the theoretical focus of ET and CBT and may support the idea of learning a way of recognizing initial or previous experiences in therapy.

B. Learning to do with self and life

Literature suggest that CBT and ET share an educational focus on learning to do with changing the way in which clients live their lives and changing the clients' assumptions and values of living (Hickes 2012; Rosenberg 2007). However, whereas CBT tend to focus on behavioural and cognitive learning

of specific capabilities and strategies for appropriate living, ET tends to focus on existential learning of capabilities for living with freedom, courage and engagement in life (Wills 2008; Deurzen 2008).

The comparison of E2 and C2 shows that participants shared the experience of learning a better sense of values and an ability to follow their own direction in life related to previous differences in this area. This finding supports the theory and highlights the importance of values and direction for the shared learning outcome of therapy. The comparison also shows that whereas participants from CBT did not articulate their learning outcome to do with life in additional terms, participants from ET tended to articulate their learning outcome to do with life in terms of learning insight into life with engagement, satisfaction and courage. Hence, life-insight with engagement, satisfaction and courage in life seem to be a specific learning outcome of ET that complies with theory.

Literature indicates a shared educational focus on beliefs about self and the world with development of a new sense of self (Hickes 2012). However, ET conceives the self as the center of the client's world experience and focuses on existential learning of authenticity that involves transformation of and caring for the self (Cohn 2005; 125; Colaizzi 2004; Cooper 2009, 139; Heidegger 2009; Pollard 2005). CBT focuses on challenging negative beliefs about the self and world and negative assumptions and behavior to do with the self and world, with a learning of more adaptive perspectives on the self and world with self-efficacy and more positive evaluation of self and future (Wills 2008, Trower 2010).

The comparison of E2 and C2 indicates a common learning outcome of a more caring and valuing self-relation with a changed self-image. However, whereas participants from ET articulate their learning outcome to do with self as related to learning a more authentic self-relation with more self-

insight, participants from CBT articulate learning a more capable self-relation with more self-esteem.

Interestingly, these findings suggest that changing self-image is a common feature of learning in CBT and ET, which seem to fit the theory. More explicit than theory, these findings point out that change in psychotherapy involves a shared learning outcome of a caring and valuing self-relation. The differences between the two groups not only reflect a theoretical difference between authenticity and self-efficacy, they suggest that increased self-esteem is a far more general outcome of CBT than indicated in the literature.

Interestingly, the findings seem to support the claim that learning to do with the world is a shared learning outcome in the sense that participants from both groups experienced becoming more active in communities and hobbies.

The findings of 22 recurrent themes in ET and the findings of 10 recurrent themes in CBT to do with self and life support a tendency towards a more diverse learning outcome in ET within this area. This might suggest that ET involves a more varied learning within this area or that it holds a stronger focus on exploring and changing to do with self and life.

C. Learning to do with thinking, acting and feeling

Literature suggest that CBT and ET include a shared educational objective that clients learn to understand and confront difficulties in living (Hickes 2010; Wills 2008; Spinelli 2007; Deurzen 2008). This involves a shared educational focus on exploring and possibly changing beliefs, behaviours and emotions with a common emphasis on the client's responsibility and ability to make choices.

However, the educational objective of CBT is to facilitate cognitive and behavioural learning of more adaptive and rational ways of thinking, acting and feeling with functional strategies for coping with difficulties (e.g. Wills 2008; Padesky 1995). On the other hand, the educational focus in ET lies in restructuring the client's Being-in-the-World by learning to understand emotions and accept anxiety with a reflected way of being, and capabilities and insight for approaching dilemmas in a personal way (Deurzen 2011; Colaizzi 2004).

Research demonstrates that for clients, successful psychotherapy involves considerations to do with making choices and ways of acting (Watson 1994).

The comparison of E3 and C3 illustrates that participants across groups experienced a common learning outcome of developing capabilities for coping with difficulties and reacting in a relaxed way. It also demonstrates that participants shared the experience of changing their way of acting and thinking and learning to make choices and take responsibility. However, the findings suggested that participants from ET experienced learning an open way of thinking and an ability to act from their own position in life, while participants from CBT experienced learning to organize their thoughts with abilities for a reflected and appropriate way of thinking and acting.

These findings support the assertion that learning to handle difficulties in living is a major shared outcome of CBT and ET. They also point to the common significance for clients of learning to make choices and take responsibility, which is most thoroughly dealt with in literature on ET. The findings indicate the importance of a changed way of thinking and acting, which literature on CBT and ET conceptualizes in rather diverse ways. Interestingly, participants do not articulate learning about emotions as an independent learning outcome but rather articulated this dimension as part of handling difficulties and reacting in a relaxed way.

Despite similarities there seems to be a significant difference between ET and CBT in terms of openness and positioning against organizing, appropriateness and reflexivity in thinking and acting. This experiential difference seems to match the theoretical difference from literature. The difference may imply that the participants from ET experience learning a personal way of thinking and acting whereas participants from CBT experience learning a structured way of organizing thoughts and behaving appropriately.

D. Learning to do with relationships with others

CBT and ET share an educational concern for the clients' interpreted view of others and emphasize relational learning (Hickes 2012, 27). However, whereas ET involves an existential focus on existential learning to engage in mutual relationships with capabilities for engaging with others in a constructive way and establishing one's separateness (Deurzen 2011, 63, 108; Spinelli 2007, 12-20), recent developments within CBT involve a behavioural and cognitive focus on interpersonal learning with emphasis of analyzing interpersonal problems and a restructuring of problematic thinking about others, which may include interpersonal problem-solving training and social skills training (Trower 2010, 93-5; Wills 2008; Ch. 3).

The comparison of E4 and C4 illustrate that participants shared the experience of learning capabilities for engaging as oneself in mutual relationships. Furthermore, a common learning outcome across the two groups was learning capabilities to accept others and set limits in relationships.

The findings of these similarities highlights the shared impact of learning about others as a major learning outcome of CBT and ET. Despite the different theoretical conceptualizations of this area

there seems to be a significant overlap between the experiences in the two groups. Interestingly, the ability to engage as oneself in mutual relationships is a joint outcome of CBT and ET and suggest a shared learning about mutuality and individuality in relationships. Furthermore, learning to accept others and set limits seem to be a common learning outcome in both group, and suggest that literature may not deal sufficiently with this aspect.

The difference in between E4 and C4 point to a slightly more varied learning outcome in CBT. While there are no peculiarities in the findings from ET, the findings from CBT and suggest that CBT additionally involve becoming more capable of choosing ones relationships and separate oneself from others as an independent person. Interestingly, separateness was a theoretical theme in ET but an experienced theme in CBT. This might support Spinelli's strong focus on interrelations in ET and suggest that in practice ET is more about learning to engage in mutual relationships as oneself than about separating oneself from others.

6.3.3. Therapy in psychotherapy

Regardless of the type of psychotherapy considered, change is the predominant goal and I have decided to look at change as learning. I am able to understand at least some psychotherapeutic methods as educational designs for learning for the client. From an educational perspective, psychotherapies differ in their explanations of how learning occurs and what it is that needs to be learned, but pursuing learning may be common.

According to Burnett, it is possible to perceive participants' responses to counselling in terms of learning and this involves the process of learning and change (Burnett 2000). According to Carey

and McLeod, many participants from psychotherapy identify learning as a necessary part of the change process or tend to articulate their outcome in terms of what they have learned (Carey 2007; McLeod 2011).

The comparison suggested a high degree of similarity between ET and CBT when it comes to the experienced learning outcome of therapy, and this similarity was to a much smaller degree reflected in the similarity between the educational objectives of ET and CBT. Yet, the comparison suggest a bigger difference when it comes to the experience of therapy and the therapist as the educational space and framework for the learning process and outcome of therapy.

A. Therapy as the educational space for learning

In my literature review, I articulated CBT and ET as learning based and learning directed therapies that involved a shared concern for clients interpreted views of self, others and the world by which clients live their life. However, CBT is based directly on learning theories that define learning as a change of behavior and cognition and CBT aims at structured learning of adaptive cognitive and behavioural capabilities with a sense of self abilities for successful living (Hickes 2012; Santrock 2008; Wills 2008; Trower 2010). Whereas I may relate ET to a learning theory that defines learning as restructuring of existence and an in-depth transformation of self and life, ET aims at learning to live resourcefully with authenticity and self-awareness (Deurzen 2011; Colaizzi 2004; Spinelli 2007; Cohn 2005).

The comparison of E5 and C6 shows that participants perceive ET as a meeting space for in-depth exploration and transformation of self, while participants perceive CBT as an educational framework

for learning that involves a self-change. Thus, the findings suggest that ET is a deeper and more comprehensive learning space than CBT, whereas CBT may be more instructional than ET. Furthermore, while participants perceive ET as a space for an authentic becoming of oneself, participants perceive CBT as a space for learning a positive self-awareness. Thus, transformation and authenticity as opposed to training or instruction and positive self-awareness.

These findings seem to underline the theoretical difference between ET and CBT. The findings highlight my suggestion that ET be perceived as an in-depth learning space and suggest the importance of conceiving CBT as an educational framework for self-change with positive self-awareness. This difference is interesting, because participants from ET experienced a learning outcome of authenticity, whereas the participants from CBT experienced a learning outcome of self-capability.

B. Facilitation of learning in therapy

The phenomenological approach involves a shift of focus from the educator-side to the learner-side and a focus on learning as a generative process, which is constantly going on (Broberg 2000, Ch. 4). From the phenomenological point of view, learning is a process where the understanding of phenomena is changed and it involves a focus on the level of processing that the learners use (Broberg 2000, 43).

Even though researchers are beginning to acknowledge learning in psychotherapy, the literature does not agree on the explanation for this learning or on possible mechanisms or principles of learning activated by psychotherapy.

Carey describes how some participants identified talking as an important factor in change, and how some participants referred to various tools and strategies that helped bring about change, which involved learning (Carey 2007). In a different article, Carey proposed exposure and reorganization as a general description of the effective principles that are applicable across different psychotherapies (Carey 2011). Likewise, Wiser suggests that different psychotherapies all facilitate the client's accessing and deepening of their experience of emotions and use different terms to describe how the client's existing framework of understanding is reorganized to a more adaptive and sufficient framework (Wiser 2001). Cooper demonstrates that technique factors may be valuable to therapy, especially in CBT (Cooper 2008, 128). Cooper also suggests that the non-directive stance in humanistic and experiential therapy may be experienced by some clients as unhelpful, whereas a deepening of experience in humanistic and experiential therapy tends to be positively related to the outcome of therapy (Cooper 2008, 140-1)

My literature review shows that in theory, CBT overall facilitates learning by using specific psycho-educational, coping and insight strategies with specific behavioural and cognitive techniques (Rosenberg 2007; Leahy 2004; Wills 2008; Trower 2010). The aim is to clarify behaviours, thoughts, emotions, beliefs, assumptions and strategies in order to make explicit potential causes for difficulties in living and correct the client's cognitive and behavioural functions by learning capabilities for adaptive and rational thinking, acting and feeling with appropriate coping and a positive sense of self (Hickes 2012). In CBT, the therapist tends to be setting the agenda (Wills 2008, 31). In theory, ET overall facilitates learning by helping the client explore and make sense of his or her experience of Being-in-the-World in relation to self, others, world and possibly the spiritual dimension (Deurzen 2008; Spinelli 2007; Cohn 2005). Existential learning involves a restructuring of the clients Being-in-the-World (Colaizzi 2004). The therapist does not use specific therapeutic

techniques but rather skills and methods for questioning, exploring and staying with the client that are rooted in the existential and philosophical tradition (Deurzen 2011; Spinelli 2007). In ET, there tends to be a focus on being with and for the client's agenda (Spinelli 2007).

The comparison of E5 and C5 demonstrates that therapeutic learning in CBT and ET commonly works through a process of exploring or perspectives that involves a certain dynamic of questioning.

However, the comparison of E5 and C5 also demonstrates that participants perceive ET as a space for learning for a life of courage, engagement and freedom, whereas participants perceive CBT as a space for learning tools for coping with thoughts, feelings and actions. Moreover, while participants perceive ET as a learning process following the clients' agenda, participants perceive CBT as a learning process based on specific techniques and directed at specific tools.

The comparison of E6 and C6 illustrates that participants across groups tended to evaluate the therapeutic approach and/or therapy as important for their learning outcome and process.

The comparison of learning outcomes in E2-4 and C2-4 may suggest a support for the claim that learning in therapy involves a reorganization and the findings to do with perspective may suggest a certain support for the claim that therapy involves some kind of exposure. However, the comparison of E5 and C6 also highlights the importance of learning through perspectives and questioning as a major shared learning mechanism and this seems supported by literature on CBT and ET.

The comparison of E5 and C5 also supports the claim that ET and CBT partially work by different learning mechanisms related to different educational agendas. Interestingly, the participants also experience a difference when it comes to therapeutic techniques, methods or skills for facilitation of learning. This finding does not seem to support the claim that the learning of tools has a general

significance for experience of change in psychotherapy, yet it seems that use of specific techniques and learning of tools is important for learning in CBT. The findings do not support the claim that non-directedness is experienced as unhelpful even though my research suggest also that ET is not just non-directive but client-following and directional. The findings support the claim of the significance of deepening the experience through exploration in ET, although ET only relate to humanistic and experiential therapy. The differences support the evaluation of the importance of the therapeutic approach as a specific educational design that has significance for the participants' experience of learning process and outcome of therapy.

6.3.4. Therapist and therapeutic relationship in psychotherapy

According to Gadamer, conversation is at the heart of understanding, and the world of phenomena reveals itself through a mutual attempt at shared understanding (Gadamer 1989, part III). To understand something is to reach an understanding with another about it, and this is only possible to achieve through a conversation that sustains the interplay of question and answer (Gadamer 1989, 368). Thus, new meaning and understanding develops between persons through the fusion of horizons (Gadamer 1989, 370). Thus, the development of new meaning in therapy relies on interpreting and understanding, which is always a dialogue between client and therapist.

Likewise, Gergen's and McNamee's social constructionist perspective on psychotherapy is inspired by hermeneutics and they see the therapeutic conversation as a social construction of the therapeutic reality (McNamee 1992, Ch. 3). Thus, the therapist and client are both active members in the conversation that involves a social co-construction of reality (McNamee 1992, Ch. 2). Hence, the therapeutic relationship is the fundamental element of the therapeutic process of change,

where the therapist and the client co-create new meaning and understanding. Therefore, therapy gives the opportunity for development of new and alternative narratives that expand the range of alternative agencies for problem solution (McNamee 1992, 31).

According to Carey, participants from psychotherapy articulated the interaction with the therapist as an important factor for change (Carey 2007). Likewise, Cooper shows how research suggests that the quality of therapeutic interaction and the therapists' level of empathy and positive regard is important for the outcome of therapy (Cooper 2008, Ch. 6). Similarly, Wampold highlights how research shows that the therapeutic relationship is a key component of psychotherapy and accounts for more in outcomes than specific ingredients (Wampold 2009, Ch. 6).

ET and especially more recent approaches to CBT both stress the importance of the therapeutic relationship (Spinelli 2007; Hickes 2012, 21; Leahy 2007). In CBT, the focus of facilitating the learning process is on a collaborative relationship where the therapist take on a very active role as a teacher, coach or consultant (Hickes 2012, 22; Wills 2008, Ch. 3). In ET, the focus of facilitating the learning process is on meeting in a mutual relationship. The therapist takes on the role of a mentor or facilitator for the clients' exploration and discovering (Deurzen 2011; Spinelli 2007).

The comparison of E5 and C5 and the comparison of E6 and C6 illustrate that participants found the therapeutic relationship important for learning in therapy. This supports the hermeneutic and social constructionist perspective of a dialogical relationship as important for the development of new meaning and understanding. Furthermore, the comparisons emphasized the important educational role of the therapist and that the therapist's work through educational qualities like guiding, revealing or sparring. The comparison also highlights the relational role of the therapist and the therapist works through relational qualities: companionship or friendship.

However, whereas participants from ET tend to perceive the therapeutic relationship as a meeting with a therapist who is being and talking with the client, participants from CBT tend to perceive the therapeutic relationship as an exchange with a therapist who is friendly, emphatic or reassuring. Furthermore, participants from ET tend to perceive the educational role of the therapist as a partner or companion who works through qualities of being knowing, aware or engaged, and the educational role is of a midwife or revelator, who works through qualities of being recognizing, assisting or supporting. Participants from CBT tend to perceive the educational role of the therapist as a guide, teacher or sparring partner.

This difference suggests that participants from ET have a more varied experience of the therapist and the therapeutic relationship. This might support Cohn's focus in ET that the therapist appear in a personal way and engage in a real relationship, and the research suggesting that a successful therapeutic experience in ET is based on the establishment of a humanized, authentic or substantial therapeutic relationship (Cohn 2005, 37; Oliviera 2012, 293).

Overall, these findings support the claim that the therapeutic relationship is essential to learning in therapy. To a certain degree, the findings on the educational role of the therapist match the theory, yet they have further suggestions for our understanding of this role. It seems that the different educational designs of ET and CBT work by giving the therapist different educational roles and this difference may account for the difference regarding the participants' experience of the learning process and outcome of therapy. Thus, in order to facilitate learning of rather specific adaptive capabilities, the CBT therapist must be a friendly, reassuring or emphatic guide, teacher or sparring partner who engages in an exchange with the client. In order to facilitate learning of authenticity and personal positioning, the ET therapist must both be a knowing, engaged or aware companion

and a recognizing, supporting or assisting revelator who engages in a meeting and is able to talk and be with the client.

6.4. Reflexivity

Reflexivity is is crucial to becoming self-aware and thus able to see any influences that could affect data collection or analysis. This process increase understanding. In the following chapter, I will reflect on my own practice as researcher during the process.

6.4.1. Reflections into data collection and analysis

The data collection was a very long and difficult process, possibly due to the criteria for recruitment. It took almost a year to recruit all the participants and perform the interviews, yet the effort seemed worthwhile as I managed to find twelve participants that met the criteria. During the process of recruitment, I found it useful to adapt the original criteria of around 12 sessions to involve 12-15 sessions in order to secure a precise recruitment. Furthermore, I needed to change my original ambition of recruiting from direct requests to therapists to include advertisement in societies and forums for therapy. I had success with these two changes, yet I might have foreseen these challenges coming and planned my recruitment procedure properly according to them. Especially, the recruitment of participants from ET posed a challenge. Perhaps because ET is not a popular approach in Denmark or perhaps because I found it necessary to include a small note in my advertisement saying that I was looking for participants from ET in line with the British school. Yet,

I had no comments or mention from participants who came forward because of this note and maybe it helped me ensure that I recruited the right participants. I asked potential participants for the name of their therapist and was able to double-check the therapists with official resources to be sure that the participants met the right criteria. However, as I mentioned earlier, I politely had to reject four potential participants who came forward as they did not meet the criteria of having had 12-15 sessions of ET or CBT.

The translation process was another time-consuming issue, yet its consequence was a far more thorough embedding in the interviews than if I had conducted them in English.

6.4.2. Influences from the researcher

IPA admits that the analysis is always an account of how the analyst thinks that the participants are thinking. Therefore, this project includes a critical reflection on researcher positioning in order for the researcher to have a neutral position and bolster the impartiality of the descriptions of each form of therapy.

A. Reflection on researcher positioning as a self

Firstly, this project involves a critical reflection on researcher positioning as self.

I have personal experience from being a client in CBT and existential therapy, and it has been important for me to consider this bias as part of my reflection. It has been very important for me during this research project to have an equal focus on CBT and existential therapy. As part of this, it

has been important to me that I could do this research project without personally preferring being a client in one type of therapy over the other. I have experienced this quality as natural throughout the project.

In reflecting upon myself and what my experience of reflexivity is and what it means to me, I looked at the process of considering the inner processes I had come to experience whilst listening to the lived experience of the twelve participants. In the interview phase, I made sure to let me guided by curiosity and openness to the participants' experience. I also paid attention to the diversity as well as the differences in the participants´ experience as clients.

The best way for me to evaluate whether I managed this is that I have been surprised during my analysis and discussion. I did not have an experience of recognition. This may be due to personal issues or it may be because I have managed to attain a high degree of curiosity and openness.

B. Reflection on researcher position as a therapist

My own training in psychotherapy has primarily focused on existential therapy, and it has been important for me to consider this bias. However, my training also involved theory on CBT. Furthermore, my interest in this research project originally based on a professional interest in developing approaches existential, cognitive and behavioural learning in educational counselling and psychotherapy. However, I lacked knowledge about the clients' lived understanding of the experience of the outcome of psychotherapy and the ways in which it involves enhancement of learning.

In this way, I was double biased. It has been very important for me during this research project to have an equal focus on CBT and existential therapy. It has also been important for me that my research project based on curiosity and not on an interest in making a mutual assessment.

My professional and educational background is reflected in my choice of research project. This clearly made it easier for me to reduce my biases in the research process. Thus, in my data gathering and in my data analysis I felt able to minimize any direct or overt discursive practice by attempting to focus solely on exploring the phenomenon. I was surprised about the complexity and richness of the participants' understanding of the lived experience of the outcome of psychotherapy. In my discussion of the research findings, I was also surprised about the degree of similarity between theory and research findings. This similarity suggests that CBT and existential therapy involves a conceptual learning not accounted for in theory.

In order to ensure the minimization, I did not work as a therapist during my data gathering, data analysis and writing up. In the interview phase, I also paid attention to the diversity as well as the differences in the participants' experiences of the roles as therapist and client. I used my therapeutic skills in these interviews. Thus, these skills made me able to focus on establishing a good relationship with the participants and make them feel safe. My skills also helped me explore the participants' experiences from their own perspective.

C. Reflection on researcher position as a researcher

In reflecting upon my own position as researcher, I looked at the process of considering my epistemological approach to this research, whilst listening to the lived experience of the twelve participants. During the interview process, I used my listening skills and in the process, I attempted

to uncover what lived meaning was like for participants. Having the privilege to enter the participants' lived worldview and listen to their lived experience, this felt like a moral responsibility of wanting to present a subjective account that was as close to their lived experience as possible.

I considered what it was about me in the role as the researcher that might have encouraged the participants to share their experiences openly with me. I concluded that some of this openness could have been facilitated by my present awareness during the interview process as well as attending to the participants with an accepting and non-judgmental attitude.

It has also been important for me not to let any theories or hypotheses lead my research but rather to let myself be led by curiosity. In order to secure this curiosity I have made sure to embed myself in the interview material as much as possible. The best way for me to evaluate whether I managed this is that I have been surprised during my analysis and discussion.

According to IPA, it is not completely attainable to bracket our own assumptions, experiences, judgments and evaluations of people. It should be noted that the same result obtained in this study is not replicable. Hence, the lived experience in my role as the researcher has been a contributing factor in shaping this process, despite the attempt to bracket any prejudices and biases.

6.4.3. Limitations of the research

Considering the limitations of this research, one can argue that the research sample was rather small, only consisting of two times six participants. Furthermore, the research sample only consisted of participants from two types of psychotherapy. However, the aim of this research was to explore the lived experience of the outcome of psychotherapy and investigate the ways in which

psychotherapy has helped to enhance learning. The small groups made it possible to conduct a nuanced and comprehensive investigation and analysis into the experienced outcome of psychotherapy. The choice of CBT and ET made it possible to research into types of psychotherapy that are already based on or easily related to a learning framework, which made it possible to compare the experienced learning outcome with intended educational objectives. My research project does not provide a general insight into the learning outcome of psychotherapy. However, my research is useful to researchers, practitioners and trainees within the fields of ET and CBT and provides a helpful perspective on how to understand the dynamic and result of psychotherapy. Furthermore, my research is helpful to the general discussion about the evaluation of psychotherapy and the attempts to provide an alternative to the medical model of psychotherapy and the clinical model of assessment.

Another limitation to consider are motivational differences. Hence, this research only consisted of participants who had sought therapy voluntarily and had not initially dropped out of therapy. Many clients are referred to psychotherapy and this research does not address the issue of how referral influences the motivation for psychotherapy. However, I found the matter of voluntariness useful in order to clarify the role of choice of therapeutic approach. Furthermore, many clients may initially drop out of therapy and this research does not address the issue of why clients drop out of therapy and what it tells about their lived experience of the outcome of psychotherapy. However, it was found useful only to interview participants who had experienced a certain length of psychotherapy in order to provide a substantial basis for the exploration of the lived experience of the outcome of psychotherapy. Finally, CBT may be more likely to be a short-term experience and designed for a more structured length of time than ET. Yet, I found it useful to interview participants who had been in therapy for equal length of time in order to enable a trustworthy comparison.

One more limitation to consider regards the recruitment process. As I found it difficult to recruit participants from direct request to therapists, I recruited many participants through advertisement. This means that most of the participants recruited had an awareness of the approach of their therapeutic experience. Hence, this aspect may reflect in the participants' understanding and evaluation of therapy. However, this procedure was necessary for the recruitment of participants and as I almost recruited an equal amount of participants in the two groups this way, this aspect should not influence the comparison of the two groups.

It is possible to propose that perhaps I should have adopted a mixed-method approach, including both quantitative and qualitative research. For instance, by measuring the quantitative level of learning and investigating in terms of how levels of learning might correlate with therapeutic approach and educational objectives. However, there might be limitations in terms of measuring an objective as well as subjective epistemological truth. Furthermore, a quantitative measuring would involve predefined and unit criteria of measurement of learning not accounted for in literature and against the idea of exploring learning as a diverse phenomenon.

Furthermore, it should be noted that the same result obtained in this study is not replicable; hence, the lived experience in my role as the researcher has been a contributing factor in shaping this process, despite the attempt to be aware of any biases.

6.5.4. Strength of the research

The most visible strength of this research is that only a few studies have been conducted exploring the lived experience of the learning outcome of psychotherapy and only a few previous studies have compared the differences and similarities between the experienced learning outcomes of different

psychotherapeutic approaches. The strength in this research is therefore the originality and ability to interview clients about their experience of psychotherapy and illustrate how this facilitated a model of learning outcome. A further strength to mention here concerns the appropriateness of the methodology used. Hence, IPA seeks to investigate the true lived experience of the phenomenon in question. So far, only few phenomenological studies have been conducted as a comparative study. This has involved utilizing research propositions for the relationship between different levels of themes or predefined criteria of comparison (Dionisio 2008; Lopez 2004, 731). One IPA study has been conducted as a comparative study (Dildar 2012). This has involved the development of contrasting themes. My research project has been groundbreaking in so far that I conducted it as an exploration of the understanding of the lived experience of different outcomes that I compared by proposing a common structure for different levels of themes that both enabled a comparison between groups of themes and a comparison of groups with a predefined criteria of objectives.

6.4.5. How does this research and its strengths inform the future of psychotherapy?

This research concerns the field of psychotherapy, because there have been only a few previous qualitative investigations of psychotherapy that have explored the learning outcome of psychotherapy. The majority of research into outcome is carried out from a quantitative vantage point with a focus on clinical efficacy instead of the learning qualities and lived experiences of psychotherapy. Therefore, this research has a clear rationale for being conducted:

- How clients can benefit and change from CBT and ET
- What role learning has in therapeutic practice

- How the therapist can enhance the client's varied learning
- How CBT and ET might be conceptualized and evaluated in terms of learning
- How qualitative IPA methodology may be effective in the investigation of the true lived experience of learning outcomes.

The justification of this research is therefore in relation to the lack of specific empirical investigations in psychotherapy of the lived experience of learning outcomes of CBT and ET.

Chapter 7. Conclusion

In conclusion, there are a number of factors to consider when reflecting on the significance of the findings in this study. These are the conclusions of the summaries, the implications for theory and practice, the validity and limitations of the sampling and methodology and how both of these inform the progression of further research into the phenomenon.

7.1. Implications for theory and practice

This project is based on the current need for a nuanced and comprehensive understanding of the outcome of psychotherapy, as part of the evaluation of the conceptual and empirical foundations of different therapeutic approaches. The intention of the project was partly to investigate an alternative to the medical model that conceptualizes psychotherapy as medical technology based on the identification of symptoms to diagnose a mental disorder and effect treatment aimed at reducing patient's mental distress (Wampold 2009, Ch. 1). Closely related to the intention of

investigating an alternative to trends within psychotherapy research were: evaluating outcome by conceptualizing change in terms of clinical outcome; providing evidence based assessment of clinical efficacy according to diagnostic measures and clinical rating scales; and mutually rating the outcome of different approaches in terms of clinical efficacy (Cooper 2008; Wampold 2009).

In my literature review, I found support within psychotherapy research for investigating the outcome of psychotherapy in terms of learning outcomes, which represent an adequate alternative to medical modellings and clinical evaluations of outcome. These outcomes are specifications of the achievements of the learner and relate to different types of educational objective that express the intentions of the educator (Moon 2002; Adam 2004). My aim was to conduct an in-depth study of the learning outcome of psychotherapy experienced in terms of the actual achievements of the learner rather than the intentions of the psychotherapist or educator. In order to achieve a nuanced and comprehensive understanding of the lived experience of the learning outcome of psychotherapy, I chose the two approaches of CBT and ET for investigation. Both of these directions show the empirical and conceptual basis for psychotherapeutic practice in terms of learning, and I showed that it was possible to formulate distinct educational objectives based on literature.

The findings of this research project strongly points to the value of evaluating the outcome of psychotherapy in terms of learning and seems to facilitate an empirical and conceptual model of learning process and outcome in the experience of psychotherapy.

7.1.1. Motivational learning

One of my research questions regarded the ways in which the choice of therapeutic approach is active or passive and what significance the motivation has for the choice. Interestingly, my findings suggested that active choice of therapeutic approach was not an aspect of the decision to go into therapy. Yet, participants tend to evaluate the therapeutic approach as important for their experience of learning in therapy. This suggest that motivation for choice of direction is not part of the previous decision making but that motivation for direction may be learned in therapy and may be part of the motivation for the client's decision to stay in therapy.

My research project provides support for the assertion that psychological motivation is important for the decision of going into psychotherapy (Schweickhardt 2009; Carey 2007). In addition, it suggests support for the claim that psychological motivation matters for the process and outcome of psychotherapy. Moreover, my research project suggests that initial psychological motivation may also be a matter of learning in psychotherapy, because findings indicate a difference in the two groups (Appendix 21A, 22 and 23). The educational design of CBT holds a stronger theoretical focus on initial commitment, which may reflect in the experience of higher motivation in the group of participants from CBT (Wills 2008, 19).

To some degree, my research supports the main assumption in psychotherapy research that clients base their decision of going into therapy on the experience of mental distress (Barker 2010, 9). There was a minor indication that participants from CBT tended to pick up clinical or diagnostic articulations of their problems from therapy, which support the theoretical framework of CBT (Hawton 2009; Dudley 2014). Interestingly, the findings showed that half of the participants in the ET group based their decision on a wish for self-knowledge. This finding challenges the assumption

that mental distress is a general motivation for going into therapy. Since choice of therapeutic approach was not a recurrent theme, the difference between the two groups suggests that maybe participants learn to address or reformulate their reason for going into therapy in light of their experience of learning in therapy. This indicates that learning to do with this issue is different in the two groups and that learning to do with motivation in CBT may be more focused on mental problems, whereas learning to do with motivation in ET may be more focused on personal growth or ethical exploration.

My discussion suggests that participants generally articulated having had an initial wish for improvement and expected to learn some capabilities in accordance with the general concept of psychotherapy. Interestingly, participants in each group tended to deepen these wishes and expectations in ways that reflect the educational objectives of respectively CBT and ET. In theory, both approaches involve an initial focus on exploring or identifying the clients' wishes and expectations of therapy and perhaps articulating the therapists' intentions and procedures (Deurzen 2011; Spinelli 2007; Cohn 2005; Wills 2008; Trower 2010). Hence, my discussion suggests that participants in the two groups also learn to address and formulate their initial wishes and expectations to therapy according to the basic theoretical assumptions in the two approaches.

Overall, my research indicates that motivational learning is an important dynamic in psychotherapy, not fully accounted for in the literature. That is, initial motivation for psychotherapy does not only seem to be something that matters to the client's previous decision making but also something that is learned in therapy; formed, maintained and perhaps enhanced. This may influence the psychological motivation and the reason for beginning and continuing therapy, as well as the wishes and expectations for the learning process and outcome of therapy.

The implications for the theory and practice of psychotherapy involve a suggestion for fully integrating motivational learning of the educational design of psychotherapy and maybe include a focus on committing clients at the beginning of psychotherapy.

7.1.2. Structure of learning outcomes of psychotherapy

My main research question regards the meaning, structure and essence of the lived experience of the outcome of CBT and ET. This involves sub questions about the ways in which the client's participation in therapy helps to enhance learning for the client; and the theoretical question about the possible difference in the lived experience of the learning outcome in CBT and ET.

Overall, my research project indicates that it makes sense to articulate the essence, meaning and structure of participants' lived experience of the outcome of psychotherapy in terms of learning. The findings involve a shared structure for the experienced learning outcomes in the two groups (Appendix 21B). Thus, my findings indicate that participants experienced the outcome of CBT and ET in three broad areas of learning: self and life; thinking, acting and feeling; and relationships with others (Appendix 21B). Other psychotherapy research by Burnett and Carey, partly support this structure (Burnett 2000; Carey 2007). To some degree, this structure reflects the theoretical similarities between ET and CBT (e.g. Hickes 2012).

I investigated learning through experiential changes that occur in the participants as the result of the therapy in which they participate (Colaizzi 1973, 45-6), with a focus upon learning as participants' changed understanding and their understanding of their experiences of these changes (Broberg 2004, 42; Smith 2010, 47). This meant that participants described learning, as they believed

it occurred to them (Giorgi 1989, 100). The shared structure expresses the participants' common experience of the learning outcome of CBT and ET in terms of the actual achievements of the participants as learners.

Change is the predominant objective, regardless of the type of therapeutic approach considered. Different psychotherapeutic approaches differ in their explanations of how change occurs and what it is that needs to change (Carey 2007). The broad perspective on learning allows an understanding of the lived experience of change from psychotherapy that is not reductionist and yet enables evaluation. Furthermore, the finding of a common structure enables a qualitative comparison that is not about establishing a mutual rating. It allows a more nuanced and comprehensive understanding of the essential similarities and differences between therapeutic approaches in terms of the actual achievements of the learners that are related to different educational objectives rather than a unit measure or clinical criteria.

Evidence based assessment tends to evaluate according to clinical criteria and mutually rate the outcome of different approaches in terms of clinical efficacy. Often these attempts involve a consideration of CBT as the first choice of approach for a range of psychiatric disorders (e.g. Tolin 2010).

Interestingly, the shared structure allowed a high degree of similarity to appear when it came to participants' lived experience of the learning outcome of ET and CBT. This difference suggests that the idea of learning outcome provides a more nuanced and comprehensive understanding of the outcome of psychotherapy. I am able to support this suggestion with my findings that participants from CBT are more likely to learn to understand and conceptualize their experiences in clinical terms, whereas participants from ET seem more likely to learn to understand and conceptualize

their experiences in ethical and existential terms. This difference is not accounted for in the clinical focus on mutual efficacy but appears in the learning approach.

Thus, the shared structure also enabled a more comprehensive understanding of the differences between ET and CBT in terms of the learners' achievements. The comparison suggests that the learning outcome of ET centers on learning authenticity and positioning in life, whereas the learning outcome of CBT centers on learning functional capabilities for an appropriate and structured way of thinking, acting and feeling. To some degree, this difference reflects the difference between the educational objectives of ET and CBT.

The shared structure is only based on findings from participants from ET and CBT but it may provide inspiration for a changed approach to assessment of the outcome of psychotherapy. For instance, the analysis of the outcome of the learning process in qualitative terms of learning outcomes makes it possible to evaluate psychotherapy by its quality. This analysis also allows evaluation of the outcome of psychotherapy according to the qualitative differences between different approaches.

7.1.3. Learning about initial and previous experiences

The idea of a learning outcome must involve an idea of what changes from psychotherapy. Literature suggests that CBT and ET involve a common educational focus on exploration or identification of clients' previous and initial experiences to do with difficulties in living (Wills 2008; Trowers 2010; Cohn 2005; Deurzen 2011; Spinelli 2007).

The findings show that participants had some previous or initial experiences, which they mainly articulated in terms of lacks and difficulties (Appendix 21C, 22 and 23). Interestingly, the comparison indicated that to a large degree, participants from the two groups shared these experiences about difficulties in life regarding self, values, direction, relationships and coping. These findings may suggest that people going into therapy share some kind of common experience about difficulties in living that they bring to therapy. However, because the shared structure of these previous experiences matches the shared structure of the learning outcomes, the findings may also suggest that participants learn to address and articulate their initial and previous experiences as part of their learning process and outcome of therapy. Thus, the exploration and identification in CBT and ET involve a learning for the participants to do with their initial and previous experiences and this learning is part of the change in psychotherapy. Interestingly, the articulations of the previous and initial experiences were far more similar in the two groups than the articulations of the learning outcomes. This may suggest that the outcome of change more than the object of change differentiate.

Thus, the educational focus in CBT and ET involve an exploration and identification of clients' difficulties that participants seem to articulate as part of learning in psychotherapy and therefore as a matter of changing the participants' experience.

The implication for theory and practice is that at least when it comes to ET and CBT, psychotherapy seems to be an educational design for changing clients' experience of difficulties in living through a learning process that involves recognition of these difficulties. This may suggest that psychotherapy should involve a thorough exploration of difficulties within the three domains of learning and a thorough way of forming the clients' experiences of these difficulties as targets of change.

7.1.4. Learning outcomes in three domains

The shared structure shows that participants commonly experienced learning outcomes of CBT and ET in three domains of learning (Appendix 21D and 22). The closer findings of these domains revealed that there are substantial similarities as well as differences between the learning that participants experienced in the two groups.

The shared learning outcome in the first domain was learning a more caring and valuing self-relation with a changed self-image, a better sense of values, and the ability to follow one's own direction in life. These findings point to a common experiential change in therapy regarding difficulties of self and life for more care, value, direction and some kind of improved perception of oneself. Thus, these findings suggest that clients generally learn a new way of identifying themselves and address their lives through therapy, at least in CBT and ET. However, the findings also suggested substantial differences between CBT and ET to do with learning for self and life. Thus, the learning outcome of ET involves learning insight into self and life with engagement, courage and satisfaction in life and an authentic self-relation, whereas the learning outcome of CBT involves learning self-capability and self-esteem.

The shared learning outcome in the second domain was learning a changed way of acting and thinking and learning capabilities for making choices, taking responsibility, coping with difficulties and reacting in a relaxed way. Thus, the findings suggest that clients generally learn an improved way of approaching difficulties and important issues in living with responsibility. However, whereas

the learning outcome of ET involves an open and positioning way of approaching living, the learning outcome of CBT involves an organized and appropriate way of approaching living.

The shared learning outcome in the third domain was learning capabilities for engaging as oneself in mutual relationships with the ability to accept others and set limits in relationships. However, the learning outcome of CBT additionally involves learning capabilities to choose one's relationships and separate oneself from others.

Learning outcomes describe the results of the learning rather than the educational objective or the learning process itself. My research involves a possibility of specifying the general and specific learning outcomes of CBT and ET, which might serve as guidelines in therapeutic practice and help to inform potential clients. It seems that there are both specific and general aspects of three learning outcomes that specify what learners will know or be able to do as a result of a learning activity in CBT and ET. Research shows that realistic expectations of therapy might improve the outcome of therapy, and specification of learning outcomes might be helpful.

Furthermore, the findings suggest two overall particular learning outcomes that express the substantial difference between ET and CBT. Thus, the particular learning outcome of ET is:

- Authenticity and insight in self, life and relationships with others with courage, engagement and freedom in an open and personal approach to difficulties and life issues

Whereas, the particular learning outcome of CBT is:

- Self-capability and self-esteem with independence in self-chosen relationships and capabilities for organized and appropriate approach to difficulties and life issues.

These particular learning outcomes might serve as guidelines for the formulation of objectives of therapy.

Furthermore, the specification of learning outcomes might usefully correlate to theory for practitioners and trainees. They help show a far more varied outcome of psychotherapy on behalf of the client than clinical measures and give a more comprehensive and nuanced understanding of the subjective experience of the result of psychotherapy than the idea of clinical efficacy.

7.1.5. Learning design

From an educational perspective, psychotherapies differ in their explanations of how learning occurs and what it is that needs to be learned. This research project provides the foundation for a framework of educational principles from which practitioners and trainees can benefit in the practice of planning, sequencing and managing learning activities in psychotherapy. This framework enables the modelling of learning processes that support the general and specific learning outcomes of CBT and ET.

From literature, I am able to articulate both CBT and ET as educational designs for the accomplishment of specific educational objectives that base on or relate to theoretical learning models. On the theoretical and hypothetical level, there are substantial similarities as well as differences between the educational designs of CBT and ET. CBT and ET are also based on different hypothetical methods, principles and techniques for the enhancement of learning in the therapeutic process.

The phenomenological approach does not only involve an analysis of the outcome of the learning process in qualitative terms. It also involves a shift of focus from the educator-side to the learner-side and a focus on learning as a generative process, which is constantly going on (Broberg 2004, 43).

From research, I can show that the learning designs of CBT and ET share a core structure with two basic learning principles that might be general for psychotherapies (Appendix 21F, 22 and 23). Motivational learning of wishes and expectations for therapy and learning about previous experiences to do with difficulties are elements of the learning process that must link to these two general principles:

G1. Exploring perspectives for altering subjective comprehension and attitude

Both CBT and ET are learning designs for self-change that work through a process of exploring or perspective. In a phenomenological perspective, learning must involve some kind of discovering, developing or revising of perspectives for the client in order to result in a positive change within the domains of self and life; thinking, acting and feeling; and relationships with others. Hence, by exploring or inquiring perspectives, the clients' subjective comprehension and attitude to self, life and others is reorganized and the client's subjective way of feeling, thinking and acting is altered. Likewise, it corresponds with a hermeneutic perspective by emphasizing meanings as created and experienced by the client in conversation with the therapist (Gadamer 1989). Thus, exploring perspectives in the therapeutic conversation facilitates the creation of a new understanding of the whole that changes the client's being and self-understanding.

G2. Questioning of experiences

In a learning perspective, this exploration of perspectives connects essentially to a dynamic of questioning. Thus, questioning of experiences is the second general principle. The first and second principle both imply that therapeutic learning demands another person and that the client would not be able to facilitate the learning process by himself or herself. The second principle suggests that a dialogical or dialectical method is essential for the learning process in psychotherapy as a form of inquiry between individuals that is based on asking and answering questions to stimulate critical reflection and illuminate experiences. Following hermeneutics, in therapy new meaning and understanding is created in a relationship. Questioning and answering have a relevance specific to the dialectical exchange or dialogical sharing. Thus, therapy may be seen as dialogically or dialectically engaged in co-creating meaning and understanding of the clients' difficulties as well as wishes and expectations of therapy. Thus, the learning basis of therapeutic questioning and answering is not simply to gather information for validating hypotheses or to interrogate the client. Rather, questioning and answering allow the therapist and the client to lead each other's range of understanding into question. Therefore, the dynamic of questioning and answering enables a mutual understanding with fusion and expansion of horizons. Furthermore, the therapeutic relationship must be engaged in evolving meaning and understanding that is specific to the dissolution of the problem. In a phenomenological perspective, questioning and answering is essential to the level of processing that the

client uses as a learner. Thus, questioning and answering facilitate the development of new understanding of phenomena for the client.

Moreover, ET has a specific learning design that I might characterize in two specific principles:

ET1. Demanding transformation of self and life

ET can be conceived as an educational framework for a complete transformation of the client's self and life. Clients must invest in this learning process, as it is demanding because it restructures the client's Being-in-the-World and it might involve experience of anxiety. This learning process is powerful by facilitating courage and valuing in life with insight into self and life and acceptance of the uncertainty of freedom in life.

ET2. Client-following, directional and in-depth exploration

Learning in ET seems to be based on an in-depth exploration of self and life that is not directive by following the client's agenda. Learning requires that therapy does not form as controlling or direction of the client and does not attempt to fix, categorize or advice to the client. Even though therapy is not directive, it is directional by helping the clients to find their own direction in life. Furthermore, learning seems to be based on a perception of this space as caring and non-judgmental, which facilitate the clients openness and expands the depth of learning.

Finally, CBT has a specific learning design that I might characterize by three learning principles:

CBT 1. Focusing on positive self-awareness

Learning in CBT seems to work through focusing on positive self-awareness that enables a positive self-change. Just as in positive psychology, the therapist must facilitate a positive focus on the client's self and this accelerates the learning of a new meaning and understanding of the self that increases the client's self-esteem and self-capability.

CBT 2. Learning of tools

CBT is a goal-directed and practice-oriented approach to therapy aimed at teaching the client tools to use in critical or stressful situations. In this respect, CBT is a learner centered planning and instruction for reaching learning goals that include specific cognitive and behavioural skills related to the identification of problems to do with maladaptive strategies and inappropriate skills. The purpose of learning tools is that the client can learn to become his or her own therapist.

CBT 3. Specific techniques for learning

CBT is also educator-centered. CBT focus on homework, planning and instruction and facilitation of learning relies on specific therapeutic techniques. Thus, CBT is a complex

technology of learning that applies standards, techniques and manuals for achieving the learning outcomes.

An important aspect of teaching and improving learning practice is to be able to clearly define the learning principles involved. It is also important to be able to clarify substantial differences from other learning approaches.

These general and specific principles give an opportunity to understand learning processes in therapeutic settings. The principles can guide practitioners and trainees to recognize the ways in which they can enhance learning for clients. The principles can also guide the training of psychotherapists and counsellors.

From Lave and Wenger, to be able to participate in the practice of psychotherapy involves that one must be able to learn a certain repertoire of competencies, and often these are not fully articulated (Lave 1991). My formulation of specific and general learning principles provides a support for this participation.

From Frank and Frank, clients must be led to believe in therapy for it to work (Frank 1991). Likewise, Wampold states that the efficacy of therapy depends on the therapist and client believing that what they do together is intended to be therapeutic (Wampold 2009, 92). The specification of general and specific learning outcomes and learning principles might help to inform both the therapist and the client about what they are engaged in doing together, which might improve their co-creation of meaning and understanding.

7.1.6. The educational role of the therapist and the learning relationship

In psychotherapy, motivational learning, learning outcomes and learning design link to the learning relationship between client and therapist and the educational role of the therapist (Appendix 21G, 22 and 23).

My research project demonstrates that learning in therapy is based on the establishment of a strong learning relationship between client and therapist. In general, the relationship constitutes an essential dynamic for facilitation of learning. Exploring and questioning in the therapeutic conversation enables the creation of a new understanding. From a hermeneutic perspective, the therapeutic conversation between client and therapist is the most central factor for learning and new horizons would not be able to open up for the client without it. From an educational perspective, the quality of the learning relationship is crucial for whether each client's openness and expression, creative and constructive potentials activate in the learning process and new understanding and meaning is generated (Juul 2002, Ch. 5).

The whole learning set-up of CBT is based on the establishment of a close therapeutic relationship that works as an exchange between therapist and client. Thus, exploring and questioning link to positive-focusing, learning of tools and use of specific techniques in an educational exchange, where the therapist must take on the rather active educational roles of guide, teacher or sparring partner for the client. It seems that an effective therapist understands that CBT involves wearing multiple hats to ensure that therapy runs smoothly and all clients receive quality learning, in which they must gradually take over more responsibility and control. Even though the therapist must take on a very active educational role and engage in some kind of educational leadership with the task of setting the agenda, it also seems that the therapist must avoid being too directive or controlling. Moreover,

in CBT the therapist must be able to work through relational qualities of empathy and friendliness in order for learning to progress.

The learning set-up in ET is based on the establishment of a learning relationship that works as a meeting between client and therapist. It seems important that this meeting be characterized as non-judgmental and with mutuality in order to facilitate the client's openness and expression for in-depth learning and transformation of self and life. The therapist must be and talk with the client and follow the client's agenda in order to enable exploring. To do this, the therapist must take on the two educational roles of companion and revelator. The companion stays with and by the client exploring by being aware, knowing or engaging. The revelator enables the client's transformation of self and life by supporting or assisting the client and giving recognition to the client's confidence and trust for learning identity and self-confidence.

The specification of the learning relationship and the educational role of the therapist are important for the practitioner's ability to enhance learning for clients. Furthermore, these specifications seem essential for the training of psychotherapists and counsellors, because they provide quite different frameworks for what the trainees must learn in order to enhance learning for clients.

7.2. Suggestion for future research in the field of psychotherapy

With the presentation of learning outcomes of ET and CBT in this study, further research is needed on the long-term learning outcome of ET and CBT and the experienced learning outcome of other psychotherapies. Future research questions could include exploring how the long term learning outcome of ET and CBT might be 2 years, 5 years or 10 years later to see what the long term outcome

is and whether there is a difference in the lasting of learning from ET and CBT. Another research question could include exploring how the lived experience of other psychotherapeutic approaches might be to see whether there are differences and similarities to the experienced learning outcomes of ET and CBT.

Given the empirical support for the learning benefits of CBT and ET reviewed and presented in this study, further research is needed on effective and practical means of teaching therapists how to enhance learning for clients.

In recent decades, research has suggested that each individual prefers different learning styles (e.g. Kolb 1984). Advocates of using this concept in education, recommend that educators assess the learning styles of the students and adapt the learning methods to fit each student's learning style. It would be interesting to investigate whether clients in psychotherapy also prefers different learning styles and how therapy might adapt to fit the client's learning style.

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Appendix 0A: Research schedule with research questions and objectives

Central research question	Research subquestions	Overall objectives	Specific objectives	Data gathering and analysis
What is the meaning, structure and essence of the lived experience of the outcome of CBT and ET?	In what ways is the choice of therapeutic approach active or passive and what significance does the motivation for the choice have?	To explore the significance of the motivation for the choice of therapy for the understanding of the lived experience of the learning outcome	To identify the clients understanding of the factors that influence their decision and choice of therapy	Interview guide, section 1 Analysis step 1-6
			To clarify, how the clients understood their experience of their own psychological motivation for therapy	
			To clarify, how the clients understood their experience of their own psychological motivation for therapy	
	In what ways has the client's participation in therapy helped to enhance learning for the client?	To explore the understanding of the lived experience of the outcome in CBT and existential therapy in Denmark and the ways in which it involves enhancement of learning.	To explore, whether clients experienced any changes in the ways they understand and relate to themselves.	Interview guide, section 2 Analysis step 1-6
			To explore if and how clients experienced any changes in their ways of thinking, acting and reacting, and their values.	
			To explore how the clients understand their	

			way of coping with difficulties and if they experienced any changes.	
			To clarify if and how clients have experienced any changes in their relationships to others and how they understand these changes.	
			To explore if and how participants experienced changes in their options to life and how they understand these changes.	
			To explore if and how participants experienced any changes in their way of taking part in the world, communities and hobbies and how they understood these changes.	
			To explore if and how the participants experienced any other learning potentials and barriers in therapy. With a focus upon how participants understood these dimensions. This also involved	

			exploring whether therapy involved their experience of any profound changes. Finally, it involved the participants' evaluation of their learning from therapy.	
	Is there a difference in the lived experience of the learning outcome of existential therapy and cognitive-behaviour therapy?	To explore differences and similarities in the understanding of the lived experience of the learning outcome of existential therapy and CBT	To identify differences and similarities between CBT and existential therapy regarding motivation for therapy and learning outcome	Analysis step 7

Appendix 0B: Timetable

Project proposal	Research	June 2010
	Programme planning module	7-8th of July 2010
	Research	July 2010-December 2010
	Submission of proposal	December 2010
	Research methods module 3	28-29th of March 2011
	Submission of RM3	6th of June 2011
	PAP Viva	22nd of June 2011
	Revising proposal	July – November 2011
	Submission of revised proposal	1st of December 2011
	Approval of revised proposal	3rd of July 2012
Ethics	Writing of ethics request	September – October 2012
	Submission of ethics request	12th of October 2012
	Rejection of ethics request	21st of November 2012
	Revising ethics request	December 2012
	Submission of revised ethics request	2nd of January 2013
	Approval of ethics request	2nd of February 2013
RP 1	Research, Literature review and Methodology	August 2012 – January 2013
	Data gathering, recruitment and interview 1	February 2013
	Transcription, translation, analysis and writing of RP1	January 2013 – July 2013
	Submission of RP1	30th July 2013
	Approval of RP 1	10th of October 2013
Final research project	Research, Literature review and Methodology	August 2013 -
	Recruitment, data gathering, interviews 2-12	July 2013 – February 2014
	Transcription and translation of interview 2-12	October 2013 - March 2014
	Data analysis	February 2014 – April 2014
	Writing up	April 2014 – July 2013
	Submission of final thesis	10th of July 2014
	Viva	3rd of February 2015
	Submission of revised thesis	March 2015

Appendix 1. Interview guide

Research questions	Interview questions
1. What significance does the motivation for the choice of modality of therapy have? The study will focus on: 1.1. The complexity of the life situation of which the client has been in, the way the client perceived his/her difficulties, and the nuanced dimensions that have brought the client to decide to start therapy	Can you tell me about your decision to start therapy? Which other people did you talk to about your decision, what did they think about it and what did they make you think? Can you mention a situation, which had impact on your decision? Can you describe it in details – what happened, what did you think, how did you experience it, which significance did it have to you?
1.2. Ideas, hopes and expectations the client has regarding the outcome of therapy	What do you hope to get out of therapy? In what ways have you thought that it would help to change your life? What do you hope will be better after therapy? What do you think that therapy could help you to achieve?
1.3. Changes in the client's experience of self-motivation in therapy, and examination of the consequences this had for learning.	Can you talk a bit about your motivation in the beginning of therapy? How was it to start in therapy? What was the therapy like? Have your ideas and hopes regarding therapy changed since you started? How have they changed? Can you describe an actual situation?
2. In what ways has the client's participation in therapy helped to enhance learning for the client? The study will focus on the clients' transformative experiences and experiences in therapy, which are expressed by: 2.1. Changes in the complexity of the way in which the clients understand and relate to themselves, modifying their fundamental assumptions about themselves in the world.	Can we talk a bit about the way you have changed your view of yourself. How did you see yourself before you started therapy? Can you remember situations in which the self-image you had created difficulties, or was a resource? When did you start noticing that the way you understand yourself has changed ... can you talk about a specific situation? How do you see yourself today? How is this different from (or the same as) the past? What are the consequences for you?
2.2. Modification of the clients understanding of their own values and direction in life, genuine new discoveries about themselves and their resources and talents.	Have you, in the course of therapy, begun to act and think in different way than you did before? Have you started to care about other things? Have you started to respond to others in a slightly different way? What does this say about you? What values are implicated? What about your sense of direction in life? How was it earlier? What has changed it? Can we talk again about your values? Have you come to a better sense of your values through? Do you remember situations where your values were challenged? What happened?
2.3. Changes in the clients' capacity to deal with difficult life situations and take responsibility to act in the social space outside the therapy sessions.	Can we talk about difficult situations and dilemmas that you have been through while you were in

	therapy? How did/do you relate to these situations? How it was before you started therapy?
2.4. Changes in the client's understanding of the importance of relationships and in their ability to analyze and understand the complexity of relationships. The consequences arising from these relationships in relation to their own wishes and needs. Changes in the client's experience of others and capacity to conceptualize others in a more complex and nuanced way: i.e. How do clients interpret and make sense of their lived experience in interaction with others? Their actions, intentions and values? In addition, what are the consequences for clients' capacity to make choices concerning their own participation in these relations?	Can you tell me a little about your actual relations with others? What do you do together? What do these relationships mean to you? How have you changed your view of relationships? Your view of their quality, depth, strength? Have you changed your ability to be yourself in these relationships? Can we talk a little about your relationships with others? In what ways have these changed since you started therapy? Can you give some detailed examples of situations, which may suggest that you relate differently than before?
2.5. Changes in the clients options to life: experience of opportunities to take responsibility, make choices and create changes in life that are in accordance with their own life goals and direction.	We have already talked a little about the difficult situations you have experienced in your life. Have you started to act differently on these challenges since you started therapy? How have you experienced your ability to cope with these situations in a different way? How do you find making choices and taking responsibility for the consequences in these situations? Has this changed during therapy?
2.6. Changes in clients' participation in society and in relevant communities, and modifications the client's experience of meaningfulness in life.	Are there any changes in your participation in various communities or hobbies? How was this possible? How did these changes occur? What does it mean for you?
2.7. Other learning potentials and learning barriers that have arisen during the course of therapy	Finally, I want to hear from you if you feel that you learned something from therapy. Has it changed your attitude towards your life and what matters most to you? What has been good in therapy? What has been less good?

Appendix 2: Transcript of interview 3 (Martha (I3)) in English

SECTION 1		
Emergent themes	**Transcript**	**Explanatory comments**
	[SECTION 1.1, A1-M5]	
Stress	A1: First. Can you tell me something about your decision to start in therapy?	
Experience of pressure Stress and pressure in previous job Decision based on stress and pressure	M1: Well, I did because in my previous job, I had a lot of stress. Um, and pressure. Therefore, I made the decision to start in therapy.	Stress and pressure in previous job Decision based on stress and pressure
	A2: Whom did you talk to about your decision?	
Talked to wife about decision Talked to friend about decision	M2: Well, I talked to my wife. Yes, I actually think it was. Yes and a good friend. Um. Actually just the two I talked to about it. My workplace did not have, no there was no one I talked to, before I started. There was not many besides those two and of course, many things were going on inside me.	Talked to wife [same sex marriage] and a good friend about decision Did not talk to anyone at workplace about decision
Mental activity around decision		Mental activity around decision
	A3: What did they made you think, those you talked too?	
Need of help Wife and friend supported need of help Work-problem too big to handle oneself Not able to get out of work-problem No longer able to control problem Wife and friend supported therapy	M3: Um, well the same that I had reached myself. That I needed some help um. It was not something I could be alone with, it had become too big for me and so difficult, that I could actually not really get out of it. That is, I had crossed that one where I could control it myself. How I felt about my body. Um. I was probably more or less send off. Yes, loving, form hand, off you go.	Wife and friend made her reach the same conclusion that she had reached herself. That she needed some help. Problem had become too big for her to handle herself. Not able to get out of problem. No longer able to control problem herself around the way she felt about her body. Wife and friend carefully send her to the therapist.
	A4: Was there a particular situation?	
Problem regarded whole life Problem regarded way of reacting Problem regarded way of approaching Able to see problem afterwards	M4: No, there was not, but it was like repeating work, that just took up too much. Looking back it has not only been at my workplace but in relation to my whole life, that how I reacted and how I have taken things to me. However, I could not see before afterwards, but also when I was in it, I could see that the thing about being stress was because I was not good enough at taking care of myself. That	Problem was repeating itself and took up mental space Problem not only regarded work-place but whole life Problem regarded the way she reacted to and approached things. Able to see problem after she was no longer in it When she was in problem she could not see it due to stress

Stress made problem unclear to oneself Previously lack of ability for self-care Previously lack of self-care as general problem Previously lack of self-care obvious at work	was not only related to my work but just became obvious there. A5: Yes M5: Yes	Previously was not good at taking care of herself Lack of ability for self-care was general problem but became obvious at work
Initial doubt about purpose of therapy Previously lack of contact with self Lack of ability to hope for therapy Choice of therapy because no other way out Lack of ability to see way out of problem Lack of ability to get out of problem Choice of therapy as necessity Gradual expectation of positive outcome Gradual expectation of self-care Gradual expectation of learning ability to say yes and no Gradual expectation of learning ability to choose to and from Gradual expectation of learning ability to feel oneself Gradual expectation of learning to react on own feelings	**[SECTION 1.2, A6-M8]** A6: What did you hope to get from therapy? M6: Well, I do not know. When I started, I actually had some doubt about what I really should and what it was all about. I was probably in so little contact with myself that I did not dare to ask myself that question. It was probably something I did because I did not feel that I had another way out. I could not keep being in what I was in, and I could not get out of it myself, so it was a bit of a necessity. However, what I hoped to get from it or what I went in to. I just think I was there. I had not really. I just think I was there. A7: What did you think would be better after therapy? M7: Well, I remember the first couple of times after therapy, where I started to feel, that this might be good for me. That maybe I could even get there, where I could start to take care of myself. Where I could take care of myself and be decent to myself. Learn to say yes and no and to and from and feel when something happens inside me. Not only feel but also react on it.	Initial doubt about what therapy was about and what she should do whit it. Did not dare to ask herself what she hope to get from therapy because she was not in contact with herself. Choice of therapy because she felt there was no other way out. Not able to get out of problem by herself. Choice of therapy felt like necessity In the beginning of therapy she started to feel that therapy could do something good for her Beginning to think that she could become able to take care of herself and be decent to herself Learn ability to say and no and choose to and from. Learn to feel herself and react on it.
Starting in therapy felt necessary Motivation as modest	**[SECTION 1.3, A8-M18, 05:33]** A8: How was your motivation at the beginning of therapy? M8: Well I probably had. I saw it like there was no other way out. I do not know how big my motivation was. It was as if I just had to um. And, and,	Starting in therapy felt like necessity and motivation was modest. Felt she had to start in therapy.

Initial doubt whether therapy was right choice Motivation as modest Decision of therapy as necessity Lack of ability to see way out of problem Anxiety Felt anxious at beginning Felt insecure at beginning Being in head in beginning Lack of ability to feel oneself Lack of ability to rest in oneself Stressful beginning Experience of therapy as doing good to self Therapy made able to relax Being met in therapy Changed wishes to outcome Increased motivation Motivation from feeling of change Wish to feel good Therapy gave peace Previously lack of ability to feel peace Therapy gave peace Give oneself permission to be Give oneself permission to accept state of things	because I did not know if it was the right thing for me. That is, I do not know how big my motivation actually was. I think that it was more, what made me start therapy was that I could see no other way out. However, whether I saw it as a motivation, I actually did not think that I did. A9: How did you experience to start therapy? M9: Filled with anxiety. I was uncomfortable and very insecure and all the time I was in my head. Difficult to feel myself and rest in myself, so in the beginning it felt stressful. However, quickly I found out that it what was actually good for me, and the way I was met made me able to relax… A10: Your wishes to the outcome of therapy, did they change during the course? M10: Yes, I think I had been there a couple of times, where I could start to feel a change that happened inside me. And. Maybe it has been a motivation for this to actually change. That I can feel good. Um. Um. I started to get a peace that I had not experienced before. I do not remember that I had experienced it before. I slowly started to see um, could feel that I um that it was okay also that I had a hard time. The thing about giving yourself permission to just be, that it is like that now, yes.	Was not sure if therapy was the right choice for her. Decision of therapy was based on necessity as she could see no other way out of her problem Anxiety Felt anxious at beginning Felt insecure Was in her head Lack of ability to feel herself Lack of ability to rest in herself Beginning felt stressful Quickly found out that therapy was good for her Therapy made her able to relax Changed wishes to the outcome of therapy when she could feel a change of herself (inside) Feeling of change motivated for therapy Wish to feel good Started to get new experience of peace Could slowly see and feel peace coming Could see that she had a hard time. Able to give herself permission to just be and accept the present state of things
SECTION 2		
Previous self-image as looking for comfort Previously looking for comfort and safety Previous self-image as looking for safety Previous self-image as avoiding conflicts Previously avoiding conflicts Previous self-image of always saying yes when meaning no	**[SECTION 2.1, A13-M20]** A11: How did you see yourself before you started therapy? M11: As a person who was looking for comfort and safety. Um also a person, who would not enter conflicts. As someone who always said yes, even though I felt like saying no. Who did not take proper care of myself. Did not listen to how I felt, did not feel myself but always were feeling	Previous self-image as person looking for comfort and safety Previous self-image as person who would not enter conflicts Previous self-image as person always saying yes even though she felt like saying no Previous self-image as person who did not take care of herself

Previous self-image as lacking self-care Previous lack of ability for self-care Previous self-image as not listening to feelings Previous lack of ability to listen to feelings Previous self-image as constant problem Previously often said yes when feeling to say no Previous self-criticism Previous self-image as problem Previously lack of ability to see self-image as problem Previous self-image as resource because people liked her Previously others saw one as good friend Previously felt could achieve from being liked Previous self-image as fake image of self-image Questioning who one is through therapy Questioning what one contains as person Questioning what own resources are Questioning what to want from life Questioning what one felt difficult in life More able to say no More able to feel what one wants	others. How they felt. Someone who did not care of herself. A12: This was how you experienced yourself? M12: Yes A13: Was this a problem for you in any contexts? M13: Yes, it has been during. I think that it has actually been the whole time. I have often managed to say yes or do some things that I actually felt like saying yes to. Then I have criticized myself so um yes, now I do not remember what you asked? A14: How did you see yourself before therapy? The way, the self-image, if it was a problem for you? M14: Well, it was a problem. However, I was not completely. I did not realize then how I was. I was just in it. A15: The self-image you had, was that a resource for you in any way? M15: Yes, there were many people who liked me. That I was a good friend and they could call me. In that way I think that I experienced that. That I used to think that I would get something out of it. That I um that others liked me, that the belief in who I was, that it was a fake image of a self-esteem um. That was what did, that I got, I thought, that I believed that I got something from it, yes. A16: This self-image, did you start to notice during therapy, that it changed? M16: Yes, I started to ask questions to who I was, and what I really contained, what kind of strengths I have, what my resources are. Where I would like to get, what am I fighting with, what I think is difficult in life, yes. Yes. So that yes, it started slowly to show itself, um, and I could start to feel, that some changes had happened. Started to say no, ask myself, do you want this and then be able to feel that I actually said no and	Previous self-image as person who did not listen to her own feelings. Previous self-image as person who was always feeling others feelings. Not taking care of oneself. Previous self-image was always a problem Often said yes to things she felt like saying no to. Self-criticism Previous self-image as problem Previous lack of ability to see that self-image was problem, because she was in it Previous self-image as resource, because people liked her Others saw her as a good friend Previously thought she could achieve something from the way she was, because others liked her Self-image was a fake image of self-esteem Believed she could achieve something from fake self-image Questioning who she was Questioning what she really contained as person. Questioning what her resources were Questioning where she wanted to get with life Questioning what she was fighting with/thought was difficult in life Showed itself Started to say no. Started to ask herself if she actually wanted

More able to feel oneself around wishes More able to say yes to what one wants Self-image as grounded Self-image as standing firm Self-image as being able to do what one wants More able to do as wants Self-image as being able to feel what one wants More able to feel what wants Self-image as more happy Self-image as more fun from being Self-image as more fun from life More able to live with uncertainty Previous tendency to seek into comfort zone Less tendency to seek into comfort zone More daring More able to be unsafe More able to be in instability	could feel that I did not want to take part in this. I did not manage this assignment; it may be something private at home. However, also that I could start say when. Some of it, that I actually would like and that I wanted to take up more space. A17: How do you see yourself today? M17: … Um, I um, I feel a lot more that I um stand with both my legs on the ground without swaying forward and back like a penny-farthing. Um, I see myself as someone who can feel and do, what I want to and say no, to what I do not want to. Um, I also see someone who is happier and um thinks that it is fun to live and be um and that, which is probably most important, I think in this therapy, because it has been to be able to live with uncertainty. To be able to live with that I do not have to know what happens in a moment. That I do not all the time have to seek into this comfort zone, that I all the time am in this little emergency shelter. That I also dare to come out where it is unsafe and the bridge swings underneath me.	options. Started to feel herself around situations where she said no Could also start say yes/to choose to/say when to things, that she actually could feel that she wanted Self-image as grounded Self-image as standing firm without swaying Self-image as person who can do what she wants to Self-image as person who can feel what she wants to Self-image as more happy Self-image as person who thinks that it is fun to live and be Becoming able to live with uncertainty Becoming able to live with that she does not know what is coming No longer has to seek into comfort zone No longer has to be in emergency shelter Dare to come out of emergency shelter when it is unsafe and unstable
	[SECTION 2.2, A18-M23] A18: Okay. Do you think that you have started to act in a different way than you used to?	
Changed way of acting More able to speak own opinion More able to reject Previously accepted things one did not like More able to notice own feelings More able to set limits More able to set limits	M18: Yes, and it um. It is something completely conscious to say things loud um, if I disagree with something, or if there is something that I do not want to take part in. A thing like, a little thing like I have always found that it was annoying when someone came to me and wanted a hug um. I have always just said, well, come and get a hug then. However, such a little thing, now I have started notice my own feelings. I do not want too, come again, to say, to set my limits. A19: Yes M19: To set some limits, yes.	Changed way of acting More able to speak her opinion if she disagrees or do not want to take part Always found it annoying when others wanted a hug, but previously she accepted it anyway Has become more able to notice her own feelings and set limits in such situations Setting limits for herself

More able to be free to be More able to be oneself in relations More energetic More acting More acting from wishes Previously lack of telling wishes Changed way of thinking No longer think in boxes No longer think in right and wrong No longer measuring No longer over-sensitive to others No longer preoccupied with what to say or do No longer thinking in finding easiest way out Wonder about possible outcome of therapy Therapy as opening up No change in object of worries	A20: Okay… M20: I think that, maybe just the thing about being freer to just be. I think that, it is also that, I belong in my surroundings. That what you see is what you get, a little like. Yes, yes. I am also a lot more energetic or acting. Um if there is something, I want now. Before it was not that important or it does not fit into the family or then, then nothing came out of it and I did not even say it loud, what I wanted, um. I do today, yes. Yes. Um. A21: Do you think that you have started to think in a different way? M21: yes, I do not think in boxes and in um in right, wrong and um measures um, and senses that much in other people. What it is I shall do or say, and what is smartest in order to get out of this conflict? A22: Is it other things that you worry about today? M22: Well, I have sometimes thought about, therapy, what will it end with? In therapy so far I think, to me is it also about opening up um and that, I think, that it is something, that comes gradually more and more. My worries, I do not know. No, no. I cannot think of anything. No… Um…	More free to be More able to be herself and others must accept that what they see it what they get More energetic More acting if there is something she wants Previously what she wanted was not important if it did not fit into the family. Previously did not speak loud what she wanted and nothing came out if it. That has changed. Changed way of thinking No longer think in boxes No longer think in right or wrong No longer measuring and sensing as much in other people No longer preoccupied with what she shall say or do. No longer thinking about what is smartest to get out of conflicts Wondering what the possible outcome of therapy might be, how far can it get her? Therapy about opening up No change in object of worries
Previously no sense of direction Previous sense of just following life More able to give direction Previously lack of ability to know what wanted More direction from knowing oneself	A23: What about your feeling of direction in life, how was it before? M23: I do not know if I had. You always have a direction, but I had no sense that I had a direction. A24: No M24: Um, I had a sense that I just followed, um and now I know how to swim the other way. I do not think that I am conscious about what, where I must go, what I wanted, who I actually was, so direction. I think that it has come nice and quiet, found out more and more about myself and um. A25: That is something that has changed? M25: What do you say? A26: This has changed.	Previously no sense of having a direction in life Previously had a sense of just following life More able to swing the other way/give a direction Previously did not know who she was or what she wanted Direction has come gradually as she has got to know herself

Significant change in sense of direction More knowledge about self More open approach to life Anxious process of learning to accept uncertainty More able to identify what wants from life More able to live according to wishes to life Previously feeling of living in prison More freedom in life Learning to live in freedom as difficult Previously unaware of having values Hard work to find values Difficult to find values Previously lack of knowing oneself Previously unaware of having values Previously values were not clear Previously resisted thinking that others had values Values must not be locked Values must be dynamic Changed values More aware of values Previously unaware of values	M26: Yes, it has changed significantly. Now um yes, it is nice to wake up and not know what shall happen and not have to put it in or make the day into. What road must we choose, but that the day. It is. I do not know what will happen now and that is great. However, it has also been filled with anxiety to get there, where I can say, it is, this is what I want and this is what I want to live according to. Yes, yes. Um. Yes, um. I think that before um before I had a thought that I was um. I probably felt like I was in a prison. Oppositely, I also felt that it could also be difficult to be in this freedom. Because I do not know what this freedom brings. A27: What about your values? Have they changed? M27: Yes, I did not know that I had values before. That is um they have. Um. I have worked very much on finding my values, um, it has really been difficult, because when you do not know yourself, it is to find out, what you really do like and who you really are and what you stand for and what I want my values to be um. That is, I did not realize before that I had values. I know that I had but they were not clear and I did not want um to think about that others had values to either. I think that I have some basic values um but I also have some values that change. I do not think of them like, I will not think of them like something that is um locked, there must be dynamics in it or be some um what is it called, yes, movement, that is good for me. A28: Your values have changed then? M28: Yes A29: What are they? M29: Yes, today I know what values I have. I did not know that before, no. A30: Was there any situations before, where your values were challenged?	Significant change in sense of direction and knowing oneself Likes that she does not know what will happen in life Like not to plan or choose road for the day Great not knowing what will happen next The road to accept being with uncertainty has been anxious More able to say what she wants in life and live according to Previously felt like she was living in prison Difficult to learn to live in freedom because she does not know what it brings Previously unaware of having values Worked hard on finding her values Difficult to find values Previously did not know herself and therefore not her values, what she wanted and what she stands for, what she wants her values to be Previously did not realize she had values Previously values were not clear Previously did not want to think about that others had values Does not want to think of her values as locked Values most be dynamic Changed values Previously now know what values were Knowing what values are

Problems of ability to feel oneself Problems of ability to feel what one wants Problems of ability to trust own feelings Value of being in nature Previously not holding on to values Values are clearer Values have changed Values are changing	M30: It was something about feeling myself, what I wanted and um. Something about daring to trust that what I felt also was right. It was something about um that for example a value to me is being in nature. Um, it really matters a lot to me, and I did not have, I knew it, but I had not done anything before, yes. That, that, that, is my values have become clearer but they have also changed and they still change.	able of feeling herself able to feel what she wants able to dare to trust what she felt was right Value of being in nature Important value Previously did not do anything about holding on to that value Values are clearer Values have changed Values are changing
	[SECTION 2.3+2.5, A31-M33] A31: How did you relate to difficult situations before?	
Previously avoidance of difficult situations Previously avoidance of difficulties for comfort and safety Previously difficult situations as anxious More able to handle freedom despite anxiety More able to live through freedom Freedom involves anxiety Freedom involves challenges More able to choose freedom against previous way of being Changed way of reacting to difficulties More able to recognize significance of own presence More able to recognize significance of own wishes More able to stay with difficulties More present around difficulties Changed way of acting Learning to know how to act	M31: Um I stuck my head between my legs. Avoided it if I could. Did not participate or did what I thought was easiest. Something about getting out of it, it was difficult, get back to comfort and safety. Um, difficult situations then were filled with anxiety. Yes, and maybe it is, yes, maybe it is exactly this freedom that, that I think can be full of anxiety but it is also were I experience to live and feel that I live. Yes, I still think it is difficult sometimes, but a challenge, yes. It is also about choices. What do I want, and I do not want to get back to where I was before. No. A32: Do you think that you react in a different way to difficulties? M32: Yes, I do. I can steel feel um how it can be difficult at my work place, when there are some conflicts, but I think that I um through therapy have found out that my presence and what I want to contribute with, that it actually also has significance. Um. Yes… I stay with it and am present in it, also when it can be difficult. Um. Yes. A33: Is it a different way to act in difficult situations? M33: I think it is something that has come gradually, nice and quiet and has taken op more and more space in	Previously avoided difficult situations Previously took the easiest way out around difficulties Previously attempted to get out of difficult situations in order to get back to comfort and safety Previously difficult situations were anxious Freedom as anxious Freedom gives possibility of experience to live and feel that lives. Freedom can still feel difficult and challenging. Freedom is a matter of choice and she does not want to return to her previous way of being Changed way of reacting to difficult situations Still feels difficulties around conflicts Therapy made her realize that her presence and wishes has a significance More able to stay with difficult situations and be present in them Changed way of acting in difficult situations Gradual changed way of acting

More able to know how to act More able to act by speaking opinion More able to act by saying from Different way of acting Changed way of thinking More present in difficult situations More able to be in difficult situations Previously ruminating around difficulties Previously ruminating around how to avoid conflicts More able to be present in difficult situations More able to feel oneself around difficulties No longer avoiding difficulties More able to accept feeling in difficult situations More able to make choices More able to make genuine choices More able to say yes when meaning yes More able to say no when meaning no More able to feel what one want More able to act on own wishes Previously lack of connection from thought to body More able to feel body More able to take responsibility	me. It is not as it is from one day to the other um how I act. Yes, but um something like for example saying what I mean, say from, say it loud and feel, that this is how I am, yes, yes. That is, I think that I act differently. A34: Do you think that you think differently when difficult situations occur? M34: Yes, I think um I think, I am more in it and just am there. Where before it was ruminating in my head, what would be the best thing to say now and what would your boss like that you say and how do you avoid getting into this conflict. The others take care of it so now I am just present; I feel it, what can be felt, and um then I can take care of it, yes. It does not mean that it will not, that I cannot feel that I get afraid and that is difficult to be in, and maybe that has been one of the biggest thing on my work place. That I must, that I do not have to eliminate or have to try to get away from, that this is difficult to be in, because this is how I feel it, and this is how I feel right now. However, it does not mean that I shall run away or run the other way. A35: What about your ability to make choices, has there been a change in it? M35: Well, today I say yes, when I mean yes and no when I mean no. I was much more able to feel what I want when I want it um and what I need and then do it. Before I was very, I did not have a connection from my brain to my body. For example, I could not breathe very well. It was here um. I can feel that there has really been a change on how I feel about my body rather than think it all in my head, yes, yes. A36: What about your ability to take responsibility? Has there been a change in it? M36: Yes, responsibility for my own life. Take responsibility and take um	Learning to know how to act More able to speak her opinion More able to say from More able to speak opinion Different way of acting Changed way of thinking around difficult situations More present and being in difficult situations Previously ruminating around what to say in difficult situations Previously ruminating around what others wanted one to say Previously ruminating around how to avoid conflicts More able to be present in difficult situations More able to feel herself around difficulties Still difficult to be in difficult situations No longer has to eliminate or get away from difficulties at work More able to accept the way she feels in difficult situations without running away Changed ability to make choices More able to say what she actually means. More able to feel what she actually wants or need and then act on it Previously no connection between brain (thoughts) and body (sensations, emotions). Changed way of feeling her body Previously thought it all in her head More able to take responsibility and control for own life

More able to control own life More able to take responsibility for own wishes More able to do what is right for one More able to feel what is right for one Process of therapy has shown her ability to responsibility for wishes More open approach to life Changed approach to life is felt from within	take control. To find out what I like. What kind of clothes I like, that is, what kind of home I like. What do I want to do tomorrow or what do I want to do now. It is really something about that it is not difficult to take this responsibility and feel and do what I know is right to me. Because I think that this is what the whole process has shown and felt like. Yes, yes, I maybe just think that there is no longer just one road that it must not go right ahead or not turn left or um that is also clear in my close family and to my colleagues at work. That is overall but just as much something, that is felt from within, um.	More able to take responsibility for what she likes and wants More able to take responsibility for what she knows is right for her Process of therapy has shown her ability to responsibility for wishes There is no longer just one road in life that must go right ahead Change is felt from within
     Changed relations Changed relations Better relations to parents More able to accept childhood Better relations to parents Better relations to sister Strengthening of relations Deselected bad friendships Previously being used in bad friendships More able to demand connection in relations	**[SECTION 2.4, A32-M38]** A37: What kind of relations do you have to other people? M37: Today or um? A38: Yes, today? M38: Um, I have some other relations, I have some, some of my circle of friends I still have, but I have also deselected some of my circle of friends. That is, um, there has been a change. I have a much better relation to my parents um than I ever had before. This is because I um off course I have looked back at my childhood but maybe there I have just released it and said, well, it was like that. Therefore, my relation to my parents have become much better um and I am getting a better friendship with my sister again. I think that my other relations have been strengthened a little more. It shows more who I am. A39: How comes that you have deselected some? M39: Um, simply because they were no good to me, it was um not something, someone um. I felt like I was a trashcan. When they needed me, they could use me and otherwise I was air. Um, today relations to me is that we must be connected, we must have something together and, and	 Changed relations Kept some of her previous circle of friends and deselected others Change in relations Better relations to parents Looked back at childhood Let go of childhood and accepted the way it was Better relations to parents Better friendship with sister Strengthening of relations Relations show more who she Deselected friends who were not good for her Felt like a trashcan to some friends Previously some friends only contacted her when they needed her (as trashcan) Now there must be a connection in relations. There must be

More able to select friendships with community Previously friendships as unilateral Changed perspective on relations More able to engage in mutual relations More able to engage in comforting and trusting relations More able to be oneself in relations	um. I felt like it was only unilateral, it was not good for me. Therefore, I choose to stop it. A40: Have you changed your perspective at what these relations mean to you? M40: Yes, I think um that it is not only me that must give and be something for others. We must be something for each other and must be able to give each other something. One must have comfort and trust and for being and saying from. There must be space so you can be exactly who you are that day. Yes.	something common in relations. Previously relations were only unilateral. Previously unilateral relations were not good for her. Changed perspective on relations because it is no longer only her that must give in relations Need of mutuality in relations Must be comfort and trust for being and saying from in relations
  Changed participation in communities More choosing in communities More participating in communities More able to be oneself in communities Change in hobbies Taken up old hobbies Engaged in new hobbies Taken up old hobbies More able to identify and follow what one wants More able to take care of oneself Value of self-care Value of creativity Value of curiosity	**[SECTION 2.6, A41-B41]** A41: Do you think that there has been a change in your participation in communities? M42: Yes, um, I think um. I both think that I can feel and I also experience, that I choose more in communities than I used to do before and I am more participating than I used to, participating with who I am. Yes. Um. A42: What about your hobbies, has there been a change? M42: Um, yes that is, I have started to paint again. I have not done that for a while. I will also start joining some meditation and um I have started to go for long walks in nature again. A43: How did these changes happen? M43: Well, actually it is about feeling what is good for me. Um and get it done um found out that it means a lot and it is significant for me. That is also one of my values. To take care of myself in that way um and start to be a little creative and curious again. Yes. That is something new [laughs].	 Changed participation in communities Choose more in communities More participation in communities More able to participate as who she is Change in hobbies Started painting again Started meditation Started to go for long walks in nature Change in hobbies because she is more able to feel what is good for her and do it Value to care of herself Value to start be creative again Value to be curious again
   Learned much from therapy More able to make own choices	[**SECTION 2.7, A44-M57]** A44: What do you think that you have learned from therapy? M44: Um I have really learned a lot. It think, I think it has been one of those things that have been important to me, that it is um that it is me, that	 Learned much from therapy

More able to identify choice as her own Learned that she must make the choice Learned that others cannot make her choices More freedom More able to choose from sense of freedom More able to be in uncertainty More able to let uncertainty be a friend Therapy has changed meaning to life Previously lack of attitude to life Previously unaware of having attitude to life Previously seeing things in contrast Attitude to life of just being in life Changed attitude to what matters in life Previously unaware of what mattered Previously lack of knowing what was important in life Therapy as creating of common space Therapy as meeting Therapy as accepting Space for being met as one is Space for being accepted as one is Therapy as non-judgmental Therapy as non-categorizing Therapy as non-explaining Client must work oneself in therapy Client must work in therapy Client must reflect in therapy Being met with care	makes the choice. It is my choice, I do. If I choose one thing then one things happens. If I choose another thing then another thing happens. They are not others who um can take some choices for me, if I do not want those choices to be made. Um. It is something about freedom and something about being in uncertainty. Let it be a friend. Um. Yes. I think that is what has mattered most to me. A45: Do you think that therapy has changed your attitude to your life? M45: Um probably more the meaning. Um I think, I am not so sure that I used to have an attitude to things. At least I did not realize that I had. Um, but it is something about going from, either it is black or white, either it is loved or hated. Those contrasts. To just be in um everything yes and maybe that is the attitude that is now, how I see myself today. A46: Do you think that therapy has changed your attitude to what matters most in life? M46: Yes, yes, yes, because now I know what matters most to me, I did not know before, I did not know what was important and what mattered in my life um yes. A47: What has been good in therapy? M47: What do you say? A48: What has been good in therapy? M48: … Well, it has been the common space that has been created. It has been a space where I feel that I have been met and accepted for who I am. I have not been judged or put in a box or told, that when you do so, you are this type of person. Rather I myself have, I had to work myself I have had to. I have had to feel and reflect and it has um but also been met in a way with care and support yes but in a liberating way. A49: What do you think has been less good in therapy?	Learned that it is important to her that she is the one who makes the choice No one else can make her choices for her Freedom Being in uncertainty Let uncertainty be a friend To let uncertainty be a friend and make her own choices is what matters most to her Therapy has changed the meaning of life Previously had no attitude to life Previously did not realize she had an attitude to life Previously things were either or More able to be in everything Changed attitude to what matters most to her Previously did not know what mattered most to her Previously did not know what was important in life. Previously did now know what mattered in life Therapy as creation of common space Has been met and accepted for who she is in therapeutic space Not being judged or categorized in therapy Not being told what one is in therapy. Had to work herself in therapy. Had to work and reflect in therapy. Has been met with care and support in therapy in a liberating way

Being met with support Being met in a liberating way Therapy as care Therapy as support Therapy as liberation Nothing less good in therapy	M49: Less good… Well I do not think that anything has been that. A50: No M50: Not what I can think of, less good… Um, I simply cannot think of anything I think is less good. No. A51: How did you experience the therapist?	Nothing less good in therapy
Therapist as being with client Therapist as support Therapist as interested Therapist as caring Therapist as accepting Positive therapeutic relationship Therapist as being curious with client Therapist not giving facts Therapist not explaining Therapist as being with client Therapist as support Therapist as midwife	M51: Um. Like someone who was with me. Support, a support. Um someone um who was very interested and um who was caring, someone who accepted me, positively that is … Yes. In addition, something about a therapist who can be curious with me. Yes. Without giving facts or tell, how things are. A52: What role did the therapist have? M52: Well like um someone who was with me um, yes what the hell. I do not know. Role. That has hard to put into words. That is, a support, yes, yes, yes… The only word I can think of is midwife [laughs] yes without… A53: Yes, good, thanks a lot.	Therapist as being with client Therapist as a support Therapist was interested Therapist as caring Therapist as accepting Positive relation Therapist as being curios with client Therapist not giving facts Therapist not telling how things are Therapist as being with client Therapist as midwife

Appendix 2B: Transcript of interview 3 (Martha (I3)) in Danish

SEKTION 1

[SEKTION 1.1, A1-M5]

A1: Allerførst. Kan du allerførst fortælle mig noget om din beslutning om at starte i terapi?
M1: Jamen, det gjorde jeg, fordi at i det arbejde jeg havde, havde rigtig meget stress, øhm, og pres og derfor så tog jeg beslutningen om at skulle starte i terapi.
A2: Hvem talte du med om den her beslutning?
M2: Jamen det talte jeg jo med min familie, min kone. Ja, jeg tror faktisk det var, ja og så en god veninde. Mm. Faktisk kun de to jeg snakkede med om det. Min arbejdsplads have ikke, nej der var ikke nogen jeg snakkede med, før jeg gik i gang. Så der var ikke ret mange andre end de to, og selvfølgelig foregik der en masse ting inden i mig.
A3: Hvad fik de dig til at tænke, dem du talte med?
M3: Øj, jamen, det samme, som jeg selv var kommet frem til, at jeg skulle have noget hjælp øh. Og det ikke var noget jeg kunne stå alene med, at det var blevet så stort for mig og så svært, så jeg kunne egentlig ikke rigtig komme ud af det, så jeg var tippet over den der hvor jeg selv kunne styre det, hvordan jeg havde det med min krop. Øhm. Så jeg blev nok mere eller mindre sendt lidt afsted. Ja. Kærlig, fast hånd, afsted med dig.
A4: Var der en bestemt situation?
M4: Nej, det var der ikke, men det var sådan gentagende arbejdsopgaver, som bare fyldte for meget, og det var vel egentlig sådan set tilbage har det været, har det ikke kun været på mit arbejde men i forhold til hele mit liv at hvordan jeg reagerede og hvordan jeg har taget ting til mig, men det kunne jeg først se bagefter, men også lidt da jeg var i det, kunne jeg se at det med at blive stresset var jo fordi, at jeg ikke kunne tage mig godt nok af mig selv, passe på mig selv. Og det var ikke kun relateret til arbejdet, men blev bare synligt der.
A5: Ja
M5: Ja

[SEKTION 1.2, A6-M8]

A6: Hvad håbede du at få ud af terapien?
M6: Ja, jeg ved ikke. Da jeg startede, så var jeg faktisk lidt i tvivl om hvad det egentlig var jeg skulle og hvad det gik ud på og jeg havde nok så lidt fat i mig selv at jeg ikke turde stille mig selv det spørgsmål. Så det var nok noget jeg gjorde fordi jeg ikke følte, at jeg havde anden udvej. Jeg kunne ikke blive ved med at være i det jeg var i, og jeg kunne ikke selv komme ud af det, så det var lidt en nødvendighed. Men hvad jeg sådan håbede på at få ud af det, eller hvad jeg gik ind til. Det havde jeg ikke sådan. Jeg tror bare, at jeg var der.
A7: Så hvad tænkte du ville være bedre efter terapien?
M7: Altså jeg kan huske de første par gange efter terapien, hvor jeg sådan begyndte at mærke, at det her det kunne godt gå hen og blive godt for mig. At jeg måske endda kunne komme derhen, hvor jeg kunne begynde at passe på mig selv. Så det der hvor jeg kunne passe på mig selv og være ordentlig over for mig selv. Lære at sige ja og nej og til og fra og mærke efter, når der sker noget i mig. Men ikke kun at mærke men også at reagere på det.

[SEKTION 1.3, A8-M18]

A8: Hvordan var din motivation i starten af terapien?

M8: Jamen jeg havde nok. Jeg så det sådan, at der var ikke anden udvej. Jeg ikke hvor stor min motivation var. Det var lidt ligesom det skulle jeg bare øh. Og, og, fordi jeg var egentlig ikke klar over, om det var det rette for mig. Så jeg ved ikke, hvor stor min motivation egentlig var. Jeg tror, det der var mere, det der gjorde at jeg tog, jeg startede i terapi, var fordi jeg ikke kunne se anden udvej. Men om jeg så det som en motivation, det tror jeg faktisk ikke at jeg gjorde.

A9: Hvordan oplevede du det at starte i terapi?

M9: Angstfyldt. Jeg var meget utryg og meget usikker og var sådan hele tiden i hovedet, svært ved at mærke mig selv og hvile i mig selv, så det opleves i starten som stressfyldt. Men hurtigt fandt jeg ud af at det var faktisk godt for mig, og den måde jeg blev mødt på gjorde at jeg faktisk kunne begynde at slappe af…

A10: Dine ønsker til hvad der skulle komme ud af den her terapi, ændrede de sig undervejs?

M10: Ja, jeg tror at jeg havde gået der et par gange, hvor jeg kunne begynde at mærke en ændring, der skete inden i mig, og det kan godt være at det har været en motivation for at det her det kan faktiske forandre. At jeg kan få det godt. Mm. Øh. Og jeg begyndte at få den her ro, som jeg ikke har oplevet før. Jeg kan ikke huske, at jeg har oplevet den før, og jeg begyndte lige så langsom at kunne se at jeg øh, kunne mærke at jeg æh at det var okay også at være at det var, at jeg også havde det svært. Det der med at give sig selv lov til bare at være, at sådan er det lige nu, ja.

SEKTION 2

[SEKTION 2.1, A13-M20]

A11: Hvordan så du på dig selv før du startede terapien?

M11: Som en person der søgte tryghed og sikkerhed. Og øh øhm en person, der ikke ville gå ind i konflikter. Som en der altid sagde ja, selv om jeg havde lyst til at sige nej. Som ikke passede ordentlig nok på mig selv, ikke lyttede efter hvordan jeg havde det, ikke mærkede efter, men altid var ude og mærke andre. Hvordan de havde det. Så en, der ikke tog sig af sig selv.

A12: Det var sådan du opfattede dig selv?

M12: Ja

A13: Var det et problem for dig i nogen sammenhænge?

M13: Ja, altså det har det jo været igennem, det synes jeg jo egentlig altid, at det har været, jeg er jo tit kommet til at sige ja eller gøre nogle ting, som jeg egentlig har haft lyst til at sige ja til, så har jeg dunket mig så øhm ja, nu kan jeg ikke huske hvad du spurgte om.

A14: Hvordan du så dig selv før terapien. Den måde det selvbillede, om det var et problem for dig?

M14: Jamen det var et problem. Men jeg var nok ikke helt, jeg var ikke klar over dengang hvordan jeg hang sådan sammen, jeg var bare i det.

A15: Det selvbillede du havde, var det en ressource for dig på nogen måde?

M15: Ja, der var rigtig mange der godt kunne lide mig, at jeg var en god veninde og kunne ringe til mig. På den måde tror jeg at jeg oplevede at, som jeg inden tænkte på at det fik jeg noget ud af. At jeg øhm at andre kunne lide mig, at troen på hvem jeg var, at det var et falsk billede på et selvværd øh. Det var det, der ligesom gjorde, at jeg fik, jeg synes, at jeg troede, at jeg fik noget ud af det, ja.

A16: Det her selvbillede, begyndte du at bemærke undervejs i terapien, at det ændrede sig?
M16: Ja, jeg begyndte jo at stille spørgsmål til hvem jeg var, og hvad jeg egentlig indeholdt, hvad er det for nogle styrker jeg har, hvad er mine ressourcer, hvor kunne jeg godt tænke mig at komme hen ad, hvad er det jeg kæmper med, det som jeg synes er besværligt i livet, ja. Ja. Så det ja, det begyndte sådan stille og roligt at vise sig, øh, og jeg kunne begynde at mærke, at der skete nogle ændringer, begyndte at kunne sige nej, spørge mig selv, har du lyst til det her og så kunne mærke at jeg rent faktisk også fik sagt nej og kunne mærke at det havde jeg egentlig ikke lyst til at deltage i, den opgave magtede jeg ikke, det kunne være noget privat hjemme. Men også at jeg kunne begynde at sige til. Noget af det, som jeg faktisk godt kunne tænke mig og som jeg gerne ville have skulle fylde noget mere.
A17: Hvordan ser du dig selv i dag?
M17: … Altså, jeg øhm jeg mærker langt mere at jeg øh at jeg står med begge ben på jorden uden at sveje frem og tilbage som sådan en væltepeter. Øhm, jeg ser mig selv som en der mærker efter og gør det, som jeg har lyst til øh og siger nej til det, som jeg ikke har lyst til, øhm, jeg ser også én, der er meget mere glad og øh synes det er sjovt at leve og være til øhm og det, der nok er vigtigst, synes jeg i hele den her terapi, for har det været øh at, at kunne leve med uvisheden, at kunne leve med, at øh jeg ikke skal vide, hvad der skal ske lige om lidt. At jeg ikke hele tiden skal søge ind i den her tryghedszone, at jeg hele tiden er i den her lille osteklokke. Men at jeg også tør at komme ud der hvor det er usikkert, og hvor broen den gynger under mig.

[SEKTION 2.2, A18-M23]
A18: Okay. Synes du, at du i løbet af terapien er begyndt at handle på en anden måde, end du gjorde før?
M18: Ja. Og den øh det er nogle helt bevidst altså, at få sagt tingene højt øhm, hvis der er noget jeg er uenig i, eller hvis der er noget, jeg ikke gider at deltage i øhm, sådan en ting som, en lille ting som at jeg altid har syntes at det var irriterende, når der var én der kom hen og ville have et kram øhm har jeg altid bare gjort og sagt, jamen så kom da hen og få et kram, men sådan en lille ting, nu er jeg begyndt at mærke efter. Jeg gider sgu ikke lige, kom igen, altså få sagt, få sat mine grænser.
A19: Ja.
M19: Få sat nogle grænser, ja.
A20: Okay…
M20: Jeg synes sådan, måske også mere bare det der med at være mere fri til bare at være. Det tror jeg, det er også det, jeg hører i mine omgivelser. At det du ser, det er det, du får, lidt agtigt ikke. Ja. Ja. Så er jeg også sådan meget mere handle-kraftig eller handle-, nu øhm, hvis der er noget, jeg gerne vil, førhen det var ikke så vigtigt, eller det passer heller ikke lige ind i familien eller så, så blev det ikke til noget alligevel og jeg fik ikke engang sagt et højt, hvad det var jeg gerne ville, øhm. Det gør jeg i dag, ja. Ja. Mm.
A21: Synes du, at du er begyndt at tænke på en anden måde?
M21: Ja, jeg tænker ikke i kasser og i øhm i rigtig og forkert og øhm måler og vejer øh og fornemmer så meget hos andre, hvad det er, jeg skal gøre eller sige, og hvad der er smartest for lige at komme ud af en konflikt.
A22: Er det nogle andre ting, du bekymrer dig om i dag?
M22: Altså, jeg har nogle gange tænkt på, terapien, hvad skal det ikke ende med. I, i den terapi indtil nu, altså der tænker jeg, for mig handler det også om at åbne op øhm og det, jeg tænker, at

det er sådan noget, der kommer gradvist mere og mere af. Min bekymringer sådan, det ved jeg sgu ikke lige. Nej, nej. Det er der ikke noget af lige, jeg kan komme i tanker om. Nej… Mm…

[SEKTION 2.3, A23-M30]

A23: Hvad med din følelse af retning i livet, hvordan var den tidligere?
M23: Jeg ved sgu ikke om jeg havde. Man har jo altid en retning, men jeg havde ikke fornemmelsen af, at jeg havde nogen retning.
A24: Nej
M24: Øh, jeg havde en fornemmelse af, at jeg bare fulgte med sådan, øh og nu kan jeg godt finde på at svømme den anden vej. Så, så jeg tror ikke, jeg er i hvert fald ikke bevidst om, hvad, hvor jeg skal hen, hvad jeg ville, hvad jeg havde lyst til, hvem jeg egentlig var, så retningen. Jeg tænker, at den er sådan kommet stille og roligt, fundet ud af mere go mere omkring mig selv og mm.
A25: Så det er noget, der har ændret sig?
M25: Hvad siger du?
A26: Det er noget, der har ændret sig?
M26: Ja, det har ændret sig markant. Nu øh ja, det er fedt at vågne op og ikke vide, hvad der skal ske og ikke skal putte det ned i eller få dagen til, hvad er det nu for en vej, vi skal dreje, men at dagen, den er, jeg aner ikke hvad der sker lige om lidt, og det er fedt, dejligt, men det har været meget angstfyldt at nå dertil, hvor jeg kan sige at, det er, det er det jeg gerne vil og det er det jeg gerne vil leve efter, ja. Ja. Mm. Ja, øh. Jeg tænker før øh førhen der havde jeg nok en tanke om at jeg var øh jeg havde det nok so om at jeg var i et fængsel. Og omvendt så syntes jeg også, nu kan det også være svært at være i den her frihed. Fordi at jeg ved ikke, hvad den byder den frihed.
A27: Hvad med dine værdier? Har de ændret sig?
M27: Ja, jeg vidste ikke, at jeg havde værdier før. Så det øh, det har de. Øhm. Jeg har arbejdet rigtig meget med at finde mine værdier, øhm, det har været rigtig svært, fordi at når man ikke kender sig selv, for så er det at finde ud af, hvad kan man egentlig godt lide, og hvem er man egentlig og hvad står man for og hvad vil jeg gerne have skal være mine værdier hmm så jeg var ikke klar over før at jeg havde værdier. Det ved jeg, at jeg havde, men de var ikke tydelige og jeg ville heller ikke øh tænke så meget over at der var andre der havde værdier. Jeg synes, at jeg har nogen sådan grundlæggende værdier øh men jeg har også nogle værdier, der skifter, så jeg tænker ikke på dem som. Jeg vil ikke tænke på dem som, jeg vil ikke tænke på dem som det er nogen der er øhm låst fast, der skal helst være skred i det eller være noget øhm hvad hedder det, ja, bevægelse, ja, det er godt for mig.
A28: Så dine værdier har ændret sig?
M28: Ja
A29: Og hvad det er for nogen?
M29: Ja, i dag ved jeg hvad jeg har for værdier. Det vidste jeg ikke før, nej.
A30: Var der nogle situationer tidligere, hvor dine værdier de blev udfordret?
M30: Det var blandt andet sådan noget med at mærke efter, hvad jeg gerne ville og øh noget med at øh turde at stole på at det jeg mærkede, det også var rigtigt, og det var øh sådan noget med at øh en værdi for mig er for eksempel at jeg er ude i naturen. Øhm, og den betyder faktisk rigtig meget for mig, og det havde jeg egentlig ikke, jeg vidste det godt, men jeg havde ikke gjort noget før, ja. Så, så, så det, mine værdier er blevet tydeligere, men de har også ændret sig, og de ændrer sig løbende.

[SEKTION 2.5, A31-M33]

A31: Vanskelige situationer, hvordan forhold du dig til dem før?

M31: Åhm ja, der stak jeg hovedet mellem benene. Undgik hvis jeg kunne. Ikke deltog eller gjorde det som jeg troede var nemmest, eller som jeg synes var nemmest. Noget med at komme ud af den her, det som var svært, komme tilbage i tryghed og sikkerhed, så øhm, så vanskelige situationer, det var, det var fyldt med angst, ja. Og måske er det, ja måske er det netop den her frihed som altså, som jeg syns både kan være angstfyldt men også det er der hvor jeg oplever at leve og mærke at jeg lever. Ja, så jeg synes stadigvæk at det er svært ind imellem, men en udfordring, ja. Men det handler om valg. Hvad vil jeg. Og jeg vil ikke tilbage der hvor jeg var før, nej.

A32: Synes du, at du reagerer på en anden måde på vanskeligheder?

M32: Ja det gør jeg. Jeg kan stadigvæk mærke øh hvordan det kan være svært for eksempel på arbejdspladsen, når der er nogen konflikter, men jeg tror måske at jeg øh igennem terapi har fundet ud af at jeg faktisk også, at min tilstedeværelse og det jeg også gerne vil bidrage med, at det faktisk også er, har betydning. Øhm. Ja… Så jeg bliver i det, og jeg er til stede i det, også når det kan være svært. Mm. Ja.

A33: Er det en anden måde at handle på i vanskelige situationer?

M33: Jeg tror, det er noget, der sådan er kommet gradvist, stille og roligt og har fået mere og mere plads i mig. Så det er ikke sådan, at det er fra den ene dag til den anden øhm som hvordan jeg handler? Ja, men øhm sådan noget som at sige, hvad jeg mener for eksempel, og få sagt fra, og få sagt til, højt og mærke, at det er lidt sådan jeg har det, ja. Ja. Så jeg synes, at jeg handler anderledes.

A34: Synes du, at du tænker anderledes, når der opstår vanskelige situationer?

M34: Ja, jeg tænker øhm jeg tror, jeg er mere i det og bare er der frem for førhen hvor det kørte oppe i hovedet med, hvad er nu det bedste at sige nu og hvad ville din chef gerne have at du siger og hvordan undgår jeg lige at komme i den her konflikt her, men at det er de andre, der tager sig af det, så nu er jeg bare til stede, jeg mærker det, der kan mærkes og øh, så kan jeg tage mig af det, ja. Og det betyder ikke, at det ikke, at jeg ikke må mærke, at jeg bliver bange, og at det er svært at være i, og det er måske det, der har været en af de største ting på min arbejdsplads, at jeg skal, at jeg ikke behøves at eliminere eller behøver at forsøge at komme væk fra, at det her det er svært at være i, for det er sådan jeg mærker det, og det er sådan jeg har det lige nu, men det betyder ikke at jeg skal stikke halen mellem benene eller løbe den anden vej. Ja. Det er okay at det er svært.

A35: Hvad med din evne til at træffe valg, er der sket nogen ændring i den?

M35: Altså, i dag siger jeg ja, når jeg mener ja, og nej, når jeg mener nej. Jeg kunne også meget bedre mærke, hvad det er jeg vil, når jeg har lyst til øhm og hvad jeg har brug for og også gør det, hvor førhen der var jeg meget, jeg havde ikke rigtig nogen forbindelse fra min hjerne og ned til min krop og for eksempel kunne jeg ikke trække vejret ret godt. Det foregik her øhm så der er virkelig sket, der kan jeg virkelig mærke en ændring på hvordan jeg, hvordan jeg har det med hele min krop frem for at jeg bare tænkte det hele i hovedet, ja. Ja.

A36: Hvad med din evne til at tage ansvar? Er der sket nogen ændring i den?

M36: Ja, ansvar for mit eget liv. Tage ansvaret og tage øhm tage styringen. Finde ud af, hvad kan jeg godt lide? Hvad for noget tøj kan jeg lide, altså, hvad for et hjem kan jeg lide? Hvad vil jeg gerne lave i morgen, eller hvad vil jeg gerne lave lige om lidt? SÅ det er virkelig noget med at, det er slet ikke svært at tage det ansvar og mærke og gøre det, jeg ved, at det er det rigtige for mig,

for det synes jeg, at hele processen her, den har vist og mærket. Ja. Ja, jeg tror bare, måske bare det der med at der ikke længere er en ikke længere én vej, at den ikke skal dreje lige ud eller at den ikke skal til venstre eller hm og at det også bliver tydeligt i min nære familie og til mine arbejdskolleger altså i det hele taget men lige så meget noget, der mærkes indefra, hm.

[SEKTION 2.4, A32-M38, 18:30-21:26]

A37: Hvad er det for nogle relationer, du har til andre mennesker?
M37: I dag, eller øh?
A38: Ja i dag?
M38: Øhm, jeg har nogle andre relationer, jeg har nogen, noget af min vennekreds har jeg stadigvæk men jeg har også valgt noget af min vennekreds fra, øhm så der er sket en ændring. Jeg har en meget bedre relation til mine forældre, øh, end jeg nogensinde har haft og det handler om at jeg øh at jeg har selvfølgelig set tilbage til min barndom men at jeg har måske der har jeg bare sluppet det og sagt, jamen sådan var det, så min relation til mine forældre, den er blevet meget bedre øhm jeg er også ved at få et bedre venskab med min søster igen, så jeg synes at de andre relationer jeg har de er blevet styrket lidt bedre. Det viser mere, hvem jeg er.
A39: Hvordan kan det være, at du har valgt nogen fra?
M39: Øhm jamen simpelthen fordi de ikke var gode for mig, det var øh det var ikke noget, nogen øhm nok lidt lige som at jeg havde det som om, at jeg var en skraldespand, at når de havde brug for hjælp så kunne jeg bruges og når jeg ikke, når der ikke var noget, så var jeg luft, øhm og relationer og for mig i dag skal være vi skal være forbundet, vi skal være noget sammen, og, og øh jeg havde det som at det kun gik den ene vej, det var ikke godt for mig, så derfor da valgte jeg at stoppe med det her.
A40: Så har du ændret dit syn på, hvad de her relationer, de betyder for dig?
M40: Ja, jeg tænker øh jeg tænker at det ikke kun er mig, der skal give og være noget for andre, men at vi skal være noget for hinanden og vi skal kunne give hinanden noget og at man skal have tryghed og tillid og også til at være og kunne sig fra og være og der skal være plads til at man lige kan være den man er den dag, ja.

[SEKTION 2.6, A41-B41]

A41: Synes du, at der er sket nogen ændring i din deltagelse i fællesskaber?
M42: Ja, øhm, jeg synes øhm jamen jeg kan både jeg kan mærke og jeg oplever også, at jeg vælger mere til i fællesskaber. End jeg har gjort før og jeg er mere deltagende end jeg har været før, deltagende med den jeg er ja. Mm.
A42: Hvad med fritidsinteresser, er der sket nogen ændring?
M42: Øhm ja altså jeg er begyndt at male igen, det har jeg ikke gjort i et stykke tid. Og så skal jeg begynde at gå til noget meditation og øh så er jeg begyndt at gå igen lange ture ude i naturen.
A43: Hvordan er de ændringer sket?
M43: Jamen det er vel egentlig fået mærke efter hvad der er godt for mig. Og øhm så også få det gjort øh fundet ud af det betyder rigtigt meget og det er betydningsfuldt for mig, og det er også en af mine værdier, at passe på mig selv på den måde øhm så også øh begynde at være lidt kreativ og nysgerrig igen, ja. Så det er noget nyt (griner).

[SEKTION 2.7, A44-M57]

A44: Hvad synes du, at du har lært af terapien?

M44: Øhm jeg har lært rigtig meget, det jeg synes, det jeg synes har været, en af de ting, der har været vigtigst for mig, det er øhm at det er mig, det er mig der træffer valget, det er mit valg jeg gør hvis jeg vælger det ene så sker der det ene, hvis jeg vælger det andet så sker der noget andet. De er ikke andre, der øhm kan tage nogle valg for mig, hvis jeg ikke har lyst til, at de valg skal træffes. Øhm så det er noget med frihed og så også at være i uvisheden, at lade den være en ven. Øhm. Ja. Det tænker jeg, at det er noget af det, der har betydet mest for mig.
A45: Synes du, at terapien har ændret din holdning til dit liv?
M45: Øh nok mere meningen. Øh jeg tror, jeg er sgu ikke så meget sikker på at jeg havde en holdning til nogen ting, jeg var i et hvert tilfælde ikke sådan lige klar over at jeg havde det, mm, men, men jo det er lidt ligesom at gå fra, at enten er det sort eller så er det hvidt eller så er det elsket eller hadet, altså de der kontraster, til bare at være øh i det hele ja og det er måske den holdning som er til, hvordan jeg ser mig selv i dag.
A46: Synes du at terapien har ændret din indstilling til, hvad der betyder mest i livet?
M46: Ja, ja, ja fordi at nu ved jeg, hvad der betyder mest lige nu, det vidste jeg ikke før, der vidste jeg ikke, hvad der var vigtigt og hvad der betød noget i mit liv øhm så jo.
A47: Hvad har været godt i terapien?
M47: Hvad siger du?
A48: Hvad har været godt i terapien?
M48: … Jamen det har været det fælles rum, der er blevet skabt, det har været et rum, hvor jeg føler at jeg er blevet mødt og accepteret som den jeg er og ikke er blevet dømt og eller skulle puttes i en kasse eller blive fortalt, at når du gør sådan, så er du den her type menneske, men at jeg selv har, jeg har selv skullet arbejde og jeg har selv skullet, jeg har ikke skullet læne mig tilbage, men jeg har selv skullet mærke efter og reflektere og så det har øh men også blevet mødt altså på en måde som med omsorg og støtte ja men alligevel på en frisættende måde.
A49: Hvad synes du har været mindre godt i terapien?
M49: Mindre godt… Jamen det er der nok ikke noget, jeg synes, der lige har været.
A50: Nej
M50: Ikke hvad jeg lige kan tænke lige nu, mindre godt… hmm det kan jeg simpelthen ikke komme i tanke om noget, jeg synes, der er mindre godt. Nej.
A51: Hvordan oplevede du terapeuten?
M51: Øhm. Som en der var med mig. Støtte, en støtte. Øh en der øhm var meget øh interesseret og øh en der var omsorgsfuld, en som accepterede mig, positivt altså… ja. Og noget med at øh en terapeut der også kan være nysgerrig sammen med mig, ja. Uden at komme med facit eller fortælle, hvordan det hang sammen.
A52: Hvilken rolle have terapeuten?
M52: Jamen altså en øh en der var sammen, en der var sammen med mig, øh ja hvad fanden det ved jeg sgu ikke rolle, det er så svært at sætte ord på, altså en støtte, ja, ja, ja… Ja det eneste ord, jeg lige kan komme i tanker om det er fødselshjælper [griner] ja uden at
A53: Ja, godt, tusind tak for det.

Appendix 3: Table of emergent themes and super-ordinate themes from Interview 3 (I3), Martha

Super-ordinate themes	Emergent themes
1. Previous problematic self-image as comfort-seeking and conflict-avoiding	Previous self-image as looking for comfort Previous self-image as looking for safety Previous self-image as avoiding conflicts Previous self-image as problem Previous self-image as constant problem
2. Previous fake self-image as resource from being liked for always saying yes	Previous self-image of always saying yes when meaning no Previous self-image as resource because people liked her Previous self-image as fake image of self-image
3. Previous lack of ability for self-care from lack of self-insight	Previous self-criticism Previous lack of ability for self-care Previously lack of self-care as general problem Previously lack of self-care obvious at work Previously lack of ability for self-care Previously lack of knowing oneself Previously lack of ability to see self-image as problem Previous self-image as lacking self-care
4. Previous lack of self-connectedness and ability to rest in oneself	Previously lack of connection from thought to body Previously lack of contact with self Lack of ability to feel oneself Lack of ability to rest in oneself Problems of ability to feel oneself
5. Previously feeling of living in un-freedom and lack of peace with black and white life-perspective	Previously lack of ability to feel peace Previously feeling of living in prison Previously seeing things in contrast
6. Previous lack of sense of attitude and direction towards life	Previously no sense of direction Previously lack of attitude to life Previously unaware of having attitude to life Previous sense of just following life Previously lack of knowing what was important in life Previously lack of ability to know what wanted Previously unaware of what mattered
7. Previously unaware of having values in life	Previously not holding on to values Previously values were not clear Previously resisted thinking that others had values Previously unaware of having values Previously unaware of values Previously unaware of having values
8. Changed self-image as grounded person more engaged and joyful in life	Self-image as grounded Self-image as standing firm Self-image as being able to do what one wants Self-image as more happy Self-image as more fun from being Self-image as more fun from life

	Self-image as being able to feel what one wants
9. More able to live in freedom involving a sense of anxiety	More able to handle freedom despite anxiety More able to live through freedom Freedom involves anxiety Freedom involves challenges More freedom More able to choose from sense of freedom More able to choose freedom against previous way of being More freedom in life More able to be free to be
10. More able to feel and live according to own wishes to life	More able to live according to wishes to life More able to identify and follow what one wants More able to act on own wishes More able to feel what wants More able to feel what one wants More able to recognize significance of own wishes More able to feel what is right for one More able to identify what wants from life
11. More able to live with uncertainty	More able to be unsafe More able to be in instability More able to live with uncertainty More able to be in uncertainty More able to let uncertainty be a friend Give oneself permission to accept state of things
12. More clear sense of values as dynamic	Value of self-care Value of creativity Value of curiosity Values must not be locked Values must be dynamic Changed values More aware of values Value of being in nature Values are clearer Values have changed Values are changing
13. More participating and engaged in communities and hobbies	Changed participation in communities More choosing in communities More participating in communities More able to be oneself in communities Change in hobbies Taken up old hobbies Engaged in new hobbies Taken up old hobbies
14. More able to control life and give direction to life	More able to give direction More direction from knowing oneself Significant change in sense of direction More able to control own life
15. More open attitude to life as felt from within	More open approach to life x2 Attitude to life of just being in life

	Changed attitude to what matters in life Changed approach to life as felt from within
16. More able to accept, take care and set limits for self	More able to take care of oneself More able to set limits x2 More able to accept childhood
17. More daring and energetic	More energetic More daring
18. More self-connected and better self-insight	More able to feel body More knowledge about self More able to feel oneself around wishes Give oneself permission to be
19. Previously avoiding anxious difficulties for seeking into comfort zone	Previously looking for comfort and safety Previously avoiding conflicts Previous tendency to seek into comfort zone Previously avoidance of difficult situations Previously avoidance of difficulties for comfort and safety Previously difficult situations as anxious
20. Previously ruminating around difficulties	Previously ruminating around difficulties Previously ruminating around how to avoid conflicts
21. Previous lack of abilities to listen to feelings	Previous lack of ability to listen to feelings Previous self-image as not listening to feelings Problems of ability to trust own feelings
22. Previously lack of ability to articulate own limits, opinions and wishes	Previously accepted things one did not like Previously often said yes when feeling to say no Previously lack of telling wishes Problems of ability to feel what one wants
23. More able to articulate own limits, opinions and wishes	More able to say no More able to speak own opinion More able to reject More able to say yes to what one wants More able to say yes when meaning yes More able to say no when meaning no
24. More able to listen to own feelings	More able to feel what one wants More able to notice own feelings
25. More open way of thinking	Changed way of thinking x2 No longer think in boxes No longer think in right and wrong No longer measuring No longer preoccupied with what to say or do No change in object of worries
26. More capable of acting from own limits, opinions and wishes	More acting More able to do as wants More able to do what is right for one Different way of acting More acting from wishes Changed way of acting x2 More able to know how to act More able to act by speaking opinion More able to act by saying from

27. More able to be present and stay with difficult situations as oneself	More present in difficult situations More able to be in difficult situations More able to be present in difficult situations More able to feel oneself around difficulties No longer avoiding difficulties More able to accept feeling in difficult situations Changed way of reacting to difficulties More able to stay with difficulties More present around difficulties Less tendency to seek into comfort zone No longer thinking in finding easiest way out
28. More able to make genuine choices and take responsibility for own wishes	More able to take responsibility More able to make own choices More able to make choices More able to identify choice as her own Process of therapy has shown her ability to responsibility for wishes More able to take responsibility for own wishes More able to make genuine choices
29. Previously tendency to engage and get used in unilateral relations in order to be liked	Previously friendships as unilateral Previously others saw one as good friend Previously felt could achieve from being liked Previously being used in bad friendships
30. Strengthening and improvement of close relations	Changed relations X2 Better relations to parents X2 Better relations to parents Strengthening of relations
31. More able to engage in mutual relations	Deselected bad friendships More able to demand connection in relations More able to select friendships with community Changed perspective on relations More able to engage in mutual relations More able to engage in comforting and trusting relations No longer over-sensitive to others
32. More able to be oneself in relations	More able to recognize significance of own presence More able to be oneself in relations x2
33. Uncontrollable problem of work-related stress and anxiety related to general way of being	Stress Experience of pressure Stress and pressure in previous job Decision based on stress and pressure Problem regarded whole life Problem regarded way of reacting Problem regarded way of approaching Work-problem too big to handle oneself Not able to get out of work-problem No longer able to control problem Able to see problem afterwards Stress made problem unclear to oneself Lack of ability to see way out of problem

	Anxiety Lack of ability to see way out of problem Lack of ability to get out of problem
34. Necessary decision of therapy discussed and supported from close relations	Talked to wife about decision Talked to friend about decision Mental activity around decision Need of help Wife and friend supported need of help Wife and friend supported therapy Decision of therapy as necessity Starting in therapy felt necessary Choice of therapy because no other way out Choice of therapy as necessity
35. Modest motivation for starting in therapy with doubt about decision and purpose of therapy	Motivation as modest Initial doubt whether therapy was right choice Motivation as modest Initial doubt about purpose of therapy
36. Gradual expectation of positive outcome as self-care and self-abilities	Gradual expectation of positive outcome Gradual expectation of self-care Gradual expectation of learning ability to say yes and no Gradual expectation of learning ability to choose to and from Gradual expectation of learning ability to feel oneself Gradual expectation of learning to react on own feelings
37. Insecurity and anxiety around stressful beginning of therapy	Felt anxious at beginning Felt insecure at beginning Being in head in beginning Stressful beginning
38. Increasing motivation from gradual feeling of change	Increased motivation Motivation from feeling of change
39. Gradual appearance of wishes and hopes to outcome as more well-being	Changed wishes to outcome Wish to feel good Lack of ability to hope for therapy Wonder about possible outcome of therapy
40. Therapist as supporting midwife being with client	Therapist as being with client x2 Therapist as support x2 Therapist as interested Therapist as caring Therapist as accepting Therapist as being curious with client Therapist not giving facts Therapist not explaining Therapist as midwife
41. Positive therapeutic relationship around therapy as caring meeting with client	Therapy as meeting Positive therapeutic relationship Being met in therapy Being met with care Being met with support Being met in a liberating way

42. Therapy as creation of common non-judgmental space for acceptance of client	Space for being met as one is Space for being accepted as one is Therapy as creating of common space Therapy as accepting Therapy as non-judgmental
43. Therapy as giving care and peace to self	Experience of therapy as doing good to oneself Therapy made able to relax Therapy gave peace X2 Therapy as support Therapy as care
44. Therapy as clients work on learning to be a genuine self through questioning	Client must work oneself in therapy Client must work in therapy Client must reflect in therapy Questioning who one is through therapy Questioning what one contains as person Questioning what own resources are Questioning what to want from life Questioning what one felt difficult in life Learned that she must make the choice Learned that others cannot make her choices Learned much from therapy Learning to know how to act
45. Therapy as liberating opening up for meaningful life	Therapy as opening up Therapy has changed meaning to life Therapy as non-categorizing Therapy as non-explaining Therapy as liberation
46. Therapy as difficult learning process of finding values and accepting uncertain freedom	Anxious process of learning to accept uncertainty Learning to live in freedom as difficult Hard work to find values Difficult to find values
47. Noting less good in therapy	Nothing less good in therapy

Appendix 4: Table of super-ordinate themes and illustrative quotes, Interview 3 (I3), Martha

Super-ordinate themes	Quote
1. Previous problematic self-image as comfort-seeking and conflict-avoiding	"..a person who was looking for comfort and safety" (M11)
2. Previous fake self-image as resource from being liked for always saying yes	"..there were many people who liked me" (M15)
3. Previous lack of ability for self-care from lack of self-insight	"..I was not good enough at taking care of myself" (M4)
4. Previous lack of self-connectedness and ability to rest in oneself	"I was probably in so little contact with myself" (M6)
5. Previously feeling of living in un-freedom and lack of peace with black and white life-perspective	"I probably felt like I was in a prison" (M26)
6. Previous lack of sense of attitude and direction towards life	"I had no sense that I had a direction" (M23)
7. Previously unaware of having values in life	"I did not know that I had values before" (M27)
8. Changed self-image as grounded person more engaged and joyful in life	"I feel a lot more that I um stand with both my legs on the ground" (M17)
9. More able to live in freedom involving a sense of anxiety	"It is something about freedom" (M44)
10. More able to feel and live according to own wishes to life	"I was much more able to feel what I want when I want it" (M35)
11. More able to live with uncertainty	"..something about being in uncertainty. Let it be a friend" (M44)
12. More clear sense of values as dynamic	"I think that I have some basic values um but I also have some values that change" (M27)
13. More participating and engaged in communities and hobbies	"I am more participating" (M42)
14. More able to control life and give direction to life	"I can say, it is, this is what I want and this is what I want to live according to" (M26)
15. More open attitude to life as felt from within	"I do not know what will happen now and that is great" (M26)
16. More able to accept, take care and set limits for self	"To take care of myself" (M43)
17. More daring and energetic	"I am also a lot more energetic" (M20)
18. More self-connected and better self-insight	"I can feel that there has really been a change on how I feel about my body rather than think it all in my head" (M35)
19. Previously avoiding anxious difficulties for seeking into comfort zone	"Something about getting out of it, it was difficult, get back to comfort and safety" (M31)
20. Previously ruminating around difficulties	"..before it was ruminating in my head" (M34)
21. Previous lack of abilities to listen to feelings	"Something about daring to trust that what I felt also was right" (M30)
22. Previously lack of ability to articulate own limits, opinions and wishes	"someone who always said yes, even though I felt like saying no" (M11)
23. More able to articulate own limits, opinions and wishes	"..be able to feel that I actually said no and could feel that I did not want to take part in this" (M16)

24. More able to listen to own feelings	"I feel it, what can be felt" (M34)
25. More open way of thinking	"I do not think in boxes and in um in right, wrong and um measures" (M21)
26. More capable of acting from own limits, opinions and wishes	"..to say, to set my limits" (M18)
27. More able to be present and stay with difficult situations as oneself	"I stay with it and am present in it, also when it can be difficult" (M32)
28. More able to make genuine choices and take responsibility for own wishes	"..it is I that makes the choice. It is my choice" (M44)
29. Previously tendency to engage and get used in unilateral relations in order to be liked	"That I was a good friend and they could call me [..] That I used to think that I would get something out of it" (M15)
30. Strengthening and improvement of close relations	". I think that my other relations have been strengthened" (M38)
31. More able to engage in mutual relations	".., today relations to me is that we must be connected, we must have something together" (M39)
32. More able to be oneself in relations	"There must be space so you can be exactly who you are that day" (M40)
33. Uncontrollable problem of work-related stress and anxiety related to general way of being	".. in my previous job, I had a lot of stress. Um, and pressure" (M1)
34. Necessary decision of therapy discussed and supported from close relations	"It was probably something I did because I did not feel that I had another way out" (M6)
35. Modest motivation for starting in therapy with doubt about decision and purpose of therapy	"I did not know if it was the right thing for me. That is, I do not know how big my motivation actually was" (M8)
36. Gradual expectation of positive outcome as self-care and self-abilities	"..maybe I could even get there, where I could start to take care of myself" (M7)
37. Insecurity and anxiety around stressful beginning of therapy	"Filled with anxiety. I was uncomfortable and very insecure and all the time I was in my head" (M9)
38. Increasing motivation from gradual feeling of change	"I could start to feel a change that happened inside me. And. Maybe it has been a motivation for this to actually change" (M10)
39. Gradual appearance of wishes and hopes to outcome as more well-being	"That I can feel good" (M10)
40. Therapist as supporting midwife being with client	".. someone who was with me. Support, a support" (M51)
41. Positive therapeutic relationship around therapy as caring meeting with client	"It has been a space where I feel that I have been met and accepted for who I am" (M48)
42. Therapy as creation of common non-judgmental space for acceptance of client	"I have not been judged or put in a box or told, that when you do so, you are this type of person" (M48)
43. Therapy as giving care and peace to self	"I started to get a peace that I had not experienced before" (M10)
44. Therapy as clients work on learning to be a genuine self through questioning	"I started to ask questions to who I was, and what I really contained, what kind of strengths I have, what my resources are" (M16)
45. Therapy as liberating opening up for meaningful life	"..in a liberating way" (M48)

46. Therapy as difficult learning process of finding values and accepting uncertain freedom	"..I do not know what will happen now and that is great. However, it has also been filled with anxiety to get there" (M26)
47. Noting less good in therapy	"Less good… Well I do not think that anything has been that" (M49)

Appendix 5: Information sheet

Information about a research project:
A Comparison of Learning Outcomes in Existential Therapy and Cognitive Behaviour Therapy
being carried out by
Anders Dræby Sørensen
As a requirement for a DProf
from NSPC and Middlesex University

NSPC Ltd
258 Belsize Road
London NW6 4BT and Middlesex University

Dated: 7th October 2012

You are being invited to take part in a research study. Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take your time to read the following information carefully, and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take your time to decide whether you wish to take part.

What is the purpose of the research?

This study is being carried out as part of my studies at NSPC Ltd and Middlesex University.

For years, researchers have studied the effects of psychotherapy. However, there has been no study of what has actually been learned from psychotherapy. If a learning framework is of value, psychotherapists might be able to use it to evaluate the outcome of psychotherapy in terms of the achievements of the learners. This could make their work even more effective and that could increase the positive impact of psychotherapy for clients. My study is designed to see how the clients actually experience the learning outcome of psychotherapy and whether the outcome is different in cognitive-behaviour therapy and existential therapy. You are being asked to participate because you have replied to my advertisement for people in ongoing therapy with selected therapists to volunteer for this project.

The study is concerned with the experiences of the participants and as such, views the research participants as co-researches whom will be invited to share as much of their experiences regarding the nature of the study.

At present, the researcher holds no prior conceptualizations regarding the research question and instead seeks to explore the topic area in more depth to gain a greater understanding. It is important to note that there are no right or wrong answers and the researcher is open to gain an insight into the experiences of the research participants.

What will happen to me if I take part?

I would like to make one interview with you. The interview will take about an hour and will include questions about your experience of learning in psychotherapy. The information from the interview will be compared with information from other participants. I will use a qualitative research method to extract the main themes of what and other people tell me about your experience of being in psychotherapy.

The interview will be transcribed and translated into English. I will not use your full or last name in the interview and the interview will be anonymized. I will be recording the interview on a digital recorder, and will transfer the files to an encrypted USB stick for storage, deleting the files from the recorder. All of the information that you provide me will be identified only with a project code and stored on the encrypted USB stick. I will keep the key that links your details with the project code in a locked cabinet.

The information will be kept at least until 6 months after I graduate, and will be treated as confidential. If my research is published, I will make sure that neither your name nor other identifying details are used.

Data will be stored according to the Danish Data Protection Act

What are the possible disadvantages of taking part?

In the interview, I shall be asking you about your experience of the psychotherapy. Talking about personal experiences may be distressing. If so, please let me know, and if you wish, I will stop the interview. Although this is very unlikely, should you tell me something that I am required by law to pass on to a third person; I will have to do so. Otherwise, whatever you tell me will be confidential.

What are the possible benefits of taking part?

We do not know much about the learning effects of psychotherapy, but it is possible that it will be helpful for some psychotherapy clients in the future. Being interviewed about your experience in therapy has no direct benefit, either, although some people may find it an opportunity to reflect on their therapy, and could find this beneficial.

6. Consent

You will be given a copy of this information sheet for your personal records, and if you agree to take part, you will be asked to sign the attached consent form before the study begins.

Participation in this research is entirely voluntary. You do not have to take part if you do not want to. If you decide to take part, you may withdraw at any time without giving a reason. See specific guidelines for consent in a separate file.

Whether or not you participate, will not affect the treatment that you are currently receiving in any way

7. Who is organizing and funding the research?

The research is funded by private means.

8. Who has reviewed the study?

All proposals for research using human participants are reviewed by an Ethics Committee before they can proceed. The NSPC research ethics sub-committee have approved this study

9. Expenses

Travel expenses will be refunded

Thank you for reading this information sheet.

If you have any further questions, you can contact me at:

Anders Dræby Sørensen
Sorgenfrigade 4, 3tv
DK-2200 Copenhagen North
Tel.: 0045 30257124
Mail: andersdraeby@yahoo.dk

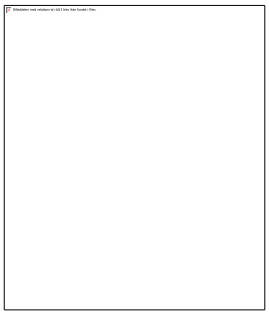
If you any concerns about the conduct of the study, you may contact my supervisor:

Rosemary Lodge
NSPC Ltd. 254-6 Belsize Road
London NW6 4BT
Mail:rosemary.lodge@virginmedia.com

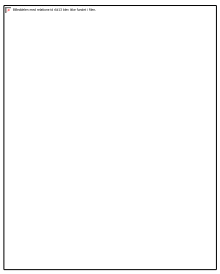
Or

The Principal
NSPC Ltd. 254-6 Belsize Road
London NW6 4BT
Admin@nspc.org.uk
0044 (0) 20 7624 0471

Appendix 6: Consent form



Written Informed Consent



Title of study and academic year: A Comparison of Learning Processes in Existential therapy and Cognitive Behaviour Therapy

Researcher: Anders Dræby Sørensen

Supervisor: Rosemary Lodge

I have understood the details of the research as explained to me by the researcher, and confirm that I have consented to act as a participant.

I have been given contact details for the researcher in the information sheet.

I understand that my participation is entirely voluntary, the data collected during the research will not be identifiable, and I have the right to withdraw from the project at any time without any obligation to explain my reasons for doing so.

I further understand that the data I provide may be used for analysis and subsequent publication, and provide my consent that this might occur.

_____ _____

Print name Sign name

Date: _____

To the participants: Data may be inspected by the Chair of the Psychology Ethics panel and the Chair of the School of Social Sciences Ethics committee of Middlesex University, if required by institutional audits about

the correctness of procedures. Although this would happen in strict confidentiality, please tick here if you do not wish your data to be included in audits: _____

Appendix 7: Ethics approval

Anders Sorensen
Sorgenfrigade 4,3
Denmark
DK2200

4th April 2013

Dear Anders

Re: Ethics Approval
We held an Ethics Board on 20th March 2013 and the following decisions were made.

Ethics Approval
Your application was approved via Chair's action and confirmed at the board.
Please note that it is a condition of this ethics approval that recruitment, interviewing, or other contact with research participants only takes place when you are enrolled in a research supervision module.

Yours sincerely

Prof Digby Tantam
Chair Ethics Committee
NSPC

Appendix 8. Existential therapy master theme 1 (E1) with table of recurrent themes

Master theme E1

Varied motivation for therapy based on mental discomfort or wish for self-knowledge. Hope for well-being, self-exploration or authenticity. Expectation of capabilities and insight for self and life.

Subsumption of recurrent super-ordinate themes for E1

Recurrent themes	I7	I8	I9	I10	I11	I12	Half
E1.1. High, modest or increasing motivation for therapy	X	X	X	X	X	X	X
E1.2. Hope or wish for authenticity, being oneself or existential learning about oneself	X	X		X		X	X
E1.3. Expectation of positive outcome as insight into or abilities to handle self or life or becoming self	X	X	X			X	X
E1.4. Decision of therapy related to problems of anxiety, phobia or stress	X		X		X		X
E1.5. Decision of therapy based on lack of well-being or experience of self-problems	X	X			X		X
E1.6. Decision of therapy based on wish for self-knowledge, self-development or self-insight		X		X		X	X
E1.7. Hope or wish for in-depth exploration or uncovering of self		X		X		X	X
E1.8. Hope or wish for happiness, well-being or removal of anxiety	X		X		X		X

Appendix 9. Existential therapy master theme 2 (E2) with table of recurrent themes

Master theme E2

Learning authentic, valuing and caring relation to oneself with changed self-image and more insight into self and life. Engagement, satisfaction and sense of direction and values with an open and courageous approach to life and participation in the world, as opposed to previous partially problematic self-relation and self-image with lack of abilities for sensing and following values and direction in life.

Subsumption of recurrent super-ordinate themes for E2

Recurrent themes	I1	I2	I3	I4	I5	I6	Half
E2.1. Previous problematic self-image	X	X	X	X		X	X
E2.2. Previous lack of self-care, self-connectedness, self-insight or ability to be oneself	X		X	X		X	X
E2.3. Previous resourceful self-image		X	X	X	X		X
E2.4. Previous negative perception of self as weak, guilty, wrong or less worth	X	X		X		X	X
E2.5. Previous unawareness, complexity or challenges around values and wishes to life	X	X	X	X			X
E2.6. Previous lack of sense of direction, groundedness, freedom or control in life	X	X	X				X
E2.7. Previous controlling, goal-directed, career oriented or self-centered attitude to life and direction				X	X	X	X
E2.8. Previously devaluating, criticizing or not accepting self or doings		X			X	X	X
E2.9. Previous valuating self around intelligence, career and professional skills		X		X	X		X
E2.10. More authenticity, self-consciousness, self-connectedness or ability to be oneself	X	X	X	X	X	X	X
E2.11. Changed self-image	X	X	X	X	X	X	X
E2.12. More loving, accepting, caring or affectionate relation to self	X	X	X	X	X	X	X
E2.13. Better sense of values or ability to stand by values	X	X	X	X	X	X	X
E2.14. More capable, satisfied, joyful, engaged, insightful or open self	X	X	X	X		X	X
E2.15. More creativity, engagement, courage, satisfaction, well-being or energy in life	X	X	X	X		X	X
E2.16. More valuing of care, engagement, happiness or being oneself	X	X	X	X	X		X
E2.17. More open, reflected, meaningful, inward, courageous or patient approach to life	X	X	X	X	X		X
E2.18. More sense of direction in life or ability to prioritize own wishes or goals in life	X	X	X	X			X

E2.19. More able to accept uncertainty, anxiety or crisis and live with freedom			X	X	X	X	X
E2.20. More desiring, engaged or chosen participation in communities or hobbies		X	X	X		X	X
E2.21. More insight into or ability to endure life		X		X		X	X
E2.22. More sense of control or positioning in life	X	X	X				X

Appendix 10. Existential therapy master theme 3 (E3) with table of recurrent themes

Master theme E3

Learning capabilities for coping with difficulties. Making genuine choices, calm way of reacting, open way of thinking. Acting from own position in life and taking own responsibility, in contrast to previous lack of capabilities to cope with difficulties and feelings. Taking responsibility and making choices.

Subsumption of recurrent super-ordinate themes for E3

Recurrent themes	I1	I2	I3	I4	I5	I6	Half
E3.1. Previous lack of abilities for constructive coping with difficulties	X	X	X	X		X	X
E3.2. Previously over-emotional, over-thinking or over-reacting around difficulties	X	X	X	X		X	X
E3.3. Previously lack of ability to be responsible or make choices	X	X			X	X	X
E3.4. Previous lack of abilities to understand, accept or cope with feelings or problems of anxiety	X		X		X		X
E3.5. More capable of relaxed, serene, reflected, present, containing or accepting way of coping with difficulties	X	X	X	X	X	X	X
E3.6. More capable of making genuine choices		X	X	X	X	X	X
E3.7. More calm, reflected, relaxed or caring way of reacting	X	X			X	X	X
E3.8. More capable of acting from own limits, values, awareness or maturity		X	X	X		X	X

Appendix 11. Existential therapy master theme 4 (E4) with table of recurrent themes

Master theme E4

Learning capabilities for engaging in mutual relationships as oneself, with abilities to set limits and respect others. This compared to previous problematic way of relating, with a lack of capabilities for constructive engagement as oneself in mutual relationships.

Subsumption of recurrent super-ordinate themes for E4

Recurrent themes	I1	I2	I3	I4	I5	I6	Half
E4.1. Previous tendency to suspiciousness, pleasing, avoidance, criticism or dependence of others	X		X	X	X	X	X
E4.2. Previously lack of ability to engage in mutual or giving relationships	X		X	X	X		X
E4.3. Previous lack of ability to be, articulate or stand by oneself in relationships				X	X	X	X
E4.4. More able to engage in mutual, giving, joyful, constructive or open relationships	X	X	X	X	X	X	X
E4.5. More able to be oneself in relationships	X	X	X	X	X		X
E4.6. More able to articulate, set limits, take confrontations, respect or accept in relationships				X	X	X	X

Appendix 12. Existential therapy master theme 5 (E5) with table of recurrent themes

Master theme E5

Therapy as a meeting space for in-depth exploration, questioning, transformation and becoming of self. Learning for a life of courage and freedom following client's agenda. Relationship to therapist as assistant revelator and companion being with and for client.

Subsumption of recurrent super-ordinate themes for E5

Recurrent themes	I1	I2	I3	I4	I5	I6	Half
E5.1. Therapy as authentic or in-depth learning to find, be or accept oneself	X	X	X	X	X	X	X
E5.2. Therapist as talking or being with client	X	X	X	X	X	X	X
E5.3. Therapy as space for caring for, unfolding of, accepting or being oneself	X	X	X	X		X	X
E5.4. Therapy as opening, clearing, exploring or unfolding through questioning, testing, reflection or perspectives		X	X	X	X		X
E5.5. Therapy as learning for life	X	X	X	X			X
E5.6. Therapy as learning of creativity, courage or valuing in life		X	X	X	X	X	X
E5.7. Therapy as meeting, commonness or client as giving oneself or taking ownership		X	X	X		X	X
E5.8. Therapy as client-following focus on client's agenda without categorizing, fixing or giving advice		X		X		X	X
E5.9. Therapist as guiding, engaged, knowing or aware partner or companion	X			X	X		X
E5.10. Therapist as authentic or recognizing support, midwife or revelator		X	X			X	X
E.5.11. Therapy as in-depth or long-term change, transformation or transgression of whole being or self	X	X				X	X
E5.12. Therapy as learning to enter or accept uncertainty and freedom			X	X		X	X

Appendix 13. Existential therapy master theme 6 (E6) with table of recurrent themes

Master theme E6

Positive therapeutic relationship and choice of approach as important for intense and demanding learning process and positive learning outcome

Subsumption of recurrent super-ordinate themes for E6

Recurrent themes	I1	I2	I3	I4	I5	I6	Half
E6.1. Positive therapeutic relationship as important	X	X		X	X	X	X
E6.2. Therapy as involving positive or fulfilling outcome		X		X	X	X	X
E6.3. Choice of therapeutic approach as important		X		X		X	X
E6.4. Therapy as involving intense, hard or difficult learning process		X	X		X		X

Appendix 14. CBT master theme 1 (C5) with table of recurrent themes

Master theme C1

High motivation for therapy reflecting in choice of therapist based on depression, anxiety and stress or emotional burden. This related to wider life problems with hope for outcome as fixing or improvement of mental state. Expectation of learning of tools for coping.

Subsumption of recurrent super-ordinate themes for C1

Recurrent themes	I7	I8	I9	I10	I11	I12	Half
C1.1. High motivation	X	X	X		X	X	X
C1.2. Decision related to problem of anxiety, stress or depression		X	X	X		X	X
C1.3. Decision related to experience of emotional burden, stuckness or problems	X				X	X	X
C1.4. Decision of therapy related to concrete problem of work, life or relations			X	X	X	X	X
C1.5. Reflected choice of therapist	X	X				X	X
C1.6. Hope for serenity or relief or improvement of mental state		X	X	X		X	X
C1.7. Hope or expectation for learning of tools or abilities for coping with anxiety, problems or thoughts	X	X		X		X	X
C1.8. Hope for fixation, normality or easier life			X	X		X	X

Appendix 15. CBT master theme 2 (C2) with table of recurrent themes

Master theme C2

Learning capabilities for capable, caring and valuing self-relation, with more positive self-image and better self-esteem. Following own values and direction in life with an open approach to life and participation in the world. In contrast with previous negative self-relation and self-image with lack of abilities for sensing and following values and direction in life.

Subsumption of recurrent super-ordinate themes for C2

Recurrent themes	I7	I8	I9	I10	I11	I12	Half
C2.1. Previous negative self-image	X	X			X	X	X
C2.2. Previously lack of ability to sense or follow values, control or direction on life	X	X			X	X	X
C2.3. Previously low self-esteem, feeling of inferiority or causing self-trouble		X	X			X	X
C2.4. More capable of self-care, self-structure or self-awareness	X	X	X	X	X	X	X
C2.5. Changed self-image	X	X	X	X	X	X	X
C2.5. More valuing, capable, present or aware perception of self	X	X	X		X	X	X
C2.6. More capable of sensing or standing up for values	X	X	X		X	X	X
C2.7. Better self-esteem	X	X	X	X	X	X	X
C2.8. More open, enterprising or relaxed approach to life		X	X	X	X	X	X
C2.9. More control, personal strength, security, groundedness, maturity or ability to follow own direction in life	X	X		X	X	X	X
C2.10. More capable of engaging in communities and hobbies		X			X	X	X

Appendix 16. CBT master theme 3 (C5) with table of recurrent themes

Master theme C3

Learning capabilities for organizing thoughts, coping with difficulties, and handling responsibility and choices, with appropriate and reflected way of acting and thinking, and a relaxed way of reacting. As opposed to a previous lack of abilities for coping with difficulties and a problematic way of thinking and acting.

Subsumption of recurrent super-ordinate themes for C3

Recurrent themes	I7	I8	I9	I10	I11	I12	Half
C3.1. Previously lack of abilities for coping with difficulties and solving problems	X	X	X		X	X	X
C3.2. Previous lack of ability to understand and cope with anxiety and anxious situations		X		X		X	X
C3.3. Previous inappropriate pattern of thinking or acting	X	X			X	X	X
C3.4. Previous lack of ability to understand, organize and reflect on thoughts and behavior	X	X	X				X
C3.5. More capable of problem solving and coping with difficulties and anxiety	X	X		X	X	X	X
C3.6. More capable of organizing thoughts or more capable way of thinking	X	X			X	X	X
C3.7. More capable of behaving and acting in a reflected way		X		X	X	X	X
C3.8. More capable of handling responsibility or making choices	X	X			X	X	X
C3.9. More capable of reacting in a reflected, resistant or relaxed way	X	X		X	X	X	X

Appendix 17. CBT master theme 4 (C5) with table of recurrent themes

Master theme C4

Learning capabilities for being oneself as an independent person, and engaging in self-chosen mutual relationships with abilities for accepting, coping with criticism, and setting limits. Compared to previous problematic way of relating and lack of ability to be oneself in relationships.

Subsumption of recurrent super-ordinate themes for C4

Recurrent themes	I7	I8	I9	I10	I11	I12	Half
C4.1. Previously submissive, role-playing or controlled by other-focus in relationships		X	X		X X	X	X
C4.2. Previously problems with limits for or criticism from others		X		X		X	X
C4.3. Previously lack of ability to be oneself in relationships		X	X		X		X
C4.4. Previous lack of connectedness, ability to engage in mutual relationships or over-responsible for others		X	X			X	x
C4.5. Social person with significant relationships	X				X	X	X
C4.6. More capable of being and understanding oneself in relationships	X	X	X		X	X	X
C4.7. More capable of accepting, coping with criticism or setting limits in relationships	X	X		X		X	X
C4.8. More capable of choosing and engaging in mutual relationships	X	X			X		X
C4.9. More able to separate oneself from others, be independent or have less other-focus		X	X			X	

Appendix 18. CBT master theme 5 (C5) with table of recurrent themes

Master theme C5

Therapy as an educational framework for learning opening of perspectives and focusing on positive self-awareness through tools for coping with thoughts, feelings and actions. This based on specific therapeutic techniques and questioning, utilizing the relationship with the therapist as guiding teacher and friendly partner for sparring.

Subsumption of recurrent super-ordinate themes for C5

Recurrent themes	I7	I8	I9	I10	I11	I12	Half
C5.1. Therapy as educational frame for learning or self-change	X	X	X	X	X		X
C5.2. Therapy as directed on learning of tools for coping with anxiety or organizing thoughts or behavior	X	X		X	X	X	X
C5.3. Therapy based on specific techniques for questioning, schemas or homework		X		X	X	X	X
C5.4. Therapy as sharing, exchange or opening of perspectives of self, life or ways of acting	X	X	X		X		X
C5.5. Therapy as focusing on self-esteem, self-care or positive awareness		X		X	X	X	X
C5.6. Therapist as friendly, empathic or reassuring guide, teacher or sparring partner	X	X		X	X		X

Appendix 19. CBT master theme 6 (C6) with table of recurrent themes

Master theme C6

Importance of good therapeutic relationship, personality of therapist and effective therapeutic approach for the learning process and a positive outcome of therapy with minor disappointments.

Subsumption of recurrent super-ordinate themes for C6

Themes	I7	I8	I9	I10	I11	I12	Half
C6.1. Importance of good or effective therapeutic relationship or personality of therapist	X	X		X		X	X
C6.2. Importance of good or effective therapeutic approach (CBT)		X		X	X	X	X
C6.3. Positive outcome as improvement of mental state, handling relationship or coping with anxiety		X		X	X	X	X
C6.4. Disappointments or impatience around process or outcome	X	X		X			X

Appendix 20: Overall table of master themes

Master theme	ET	CBT
1. Motivation	Varied motivation for therapy based on mental discomfort or wish for self-knowledge. Hope for well-being, self-exploration or authenticity. Expectation of capabilities and insight for self and life.	High motivation for therapy reflecting in choice of therapist based on depression, anxiety and stress or emotional burden. This related to wider life problems with hope for outcome as fixing or improvement of mental state. Expectation of learning of tools for coping.
2. Learning outcome to do with self and life	Learning authentic, valuing and caring relation to oneself with changed self-image and more insight into self and life. Engagement, satisfaction and sense of direction and values with an open and courageous approach to life and participation in the world, as opposed to previous partially problematic self-relation and self-image with lack of abilities for sensing and following values and direction in life.	Learning capabilities for capable, caring and valuing self-relation, with more positive self-image and better self-esteem. Following own values and direction in life with an open approach to life and participation in the world. In contrast with previous negative self-relation and self-image with lack of abilities for sensing and following values and direction in life.
3. Learning outcome to do with thinking, acting and feeling	Learning capabilities coping with difficulties. Making genuine choices, calm way of reacting, open way of thinking. Acting from own position in life and taking own responsibility, in contrast to previous lack of capabilities to cope with difficulties and feelings. Taking responsibility and making choices.	Learning capabilities organizing thoughts, coping with difficulties, and handling responsibility and choices, with appropriate and reflected way of acting and thinking and relaxed way of reacting. As opposed to a previous lack of abilities for coping with difficulties and a problematic way of thinking and acting.
4. Learning outcome around relationships with others	Learning capabilities for engaging in mutual relationships as oneself with abilities to set limits and respect others from previous problematic way of relating with lack of capabilities for constructive engagement as oneself in mutual relationships	Learning capabilities for being oneself as independent person and engaging in self-chosen mutual relationships with abilities for accepting, coping with criticism and setting limits from previous problematic way of relating and lack of ability to be oneself in relationships
5. Perception of therapy and therapist	Therapy as a meeting space for in-depth exploration, questioning,	Therapy as an educational framework for learning opening

	transformation and becoming of self. Learning for a life of courage and freedom following client's agenda. Relationship to therapist as assistant revelator and companion being with and for client.	of perspectives and focusing on positive self-awareness through tools for coping with thoughts, feelings and actions. This based on specific therapeutic techniques and questioning, utilizing the relationship with the therapist as guiding teacher and friendly partner for sparring.
6. Evaluation of learning outcome and learning process	Positive therapeutic relationship and choice of approach as important for intense and demanding learning process and positive learning outcome.	Importance of good therapeutic relationship, personality of therapist and effective therapeutic approach for the learning process and a positive outcome of therapy with minor disappointments.

Appendix 21: Conclusion tables

21A. Motivational learning:

General (ET+CBT)	Specific (ET)	Specific (CBT)
Learning motivation for therapy with articulation of initial wish for improvement and expectation of learning capabilities	Learning motivation for ET with formulation of motivational experience of mental distress or wish for self-knowledge and addressing of initial wishes for authenticity and self-exploration and expectation of learning capabilities for self and life	Learning motivation for CBT with formulation of motivational experience of mental distress or mental disorders and addressing of initial wishes for fixation of improvement of mental state and expectation of learning tools for coping with thoughts, actions and feelings

21B. Overall structure of learning outcomes of psychotherapy:

Learning outcome 1	Learning outcome 2	Learning outcome 3
Learning to do with self and life	Learning to do with thinking, acting and feeling	Learning to do with relationships with others

21C. Learning about initial and previous experiences:

Learning domain	General (ET+CBT)	Specific (ET)	Specific (CBT)
1. Self and life	Learning about problematic self-image and self-relation and lack of abilities to follow values and direction in life		
2. Thinking, acting and feeling	Learning about lack of abilities for coping with difficulties	Learning about lack of abilities for taking responsibility and making choices	Learning about problematic way of thinking and acting
3. Relations to others	Learning about problematic way of relating with lack of abilities to engage as oneself in relationships		

21D. Learning outcomes in three domains:

Learning domain	General (ET+CBT)	Specific (ET)	Specific (CBT)
Self and life	Learning a caring and valuing self-relation with a changed self-image and capabilities for following values and direction in life	Learning authentic self-relation, more self-insight and insight into life with engagement, satisfaction and courage in life	Learning self-capability and self-esteem.
Thinking, acting and feeling	Learning a more caring and valuing self-relation with a changed self-image, a better sense of values and ability to follow own direction in life	Learning an open and positioning way of approaching living	Learning an organized and appropriate way of approaching living
Relations to others	Learning to engage as oneself in mutual relationships with abilities to accept others and set limits in relationships		Learning capabilities to choose one's relationships and separate oneself from others

21E. Overall particular learning outcomes:

ET	CBT
Authenticity and insight in self, life and relations to others with courage, engagement and freedom in an open and personal approach to difficulties and life issues	Self-capability and self-esteem with independence in self-chosen relations and capabilities for organized and appropriate approach to difficulties and life issues.

21F. Learning design:

Principle	General (ET+CBT)	Specific (ET)	Specific (CBT)
1	Exploring perspectives for altering subjective comprehension and attitude	Demanding transformation of self and life	Focusing on positive self-awareness
2	Questioning experiences	Client-following, directional and in-depth exploration	Learning of tools

3			Specific techniques for learning

21G. Educational role of therapist and learning relationship:

Principle	**General (ET+CBT)**	**Specific (ET)**	**Specific (CBT)**
Educational role of therapist	Educational role for facilitation of learning	Companion and revelator	Guide, teacher or partner
Educational qualities of therapist	Educational qualities for facilitation of learning	Aware, knowing or engaging	Guiding, teaching or partnering
Therapeutic relationship	Strong learning relationship	Non-judgmental and mutual meeting	Exchange
Relational qualities of therapist	Relational qualities for facilitation of learning	Supporting, assisting and giving recognition	Empathy and friendliness

Appendix 22. Overall conclusion table

Basic learning principles		General (ET+CBT)	Specific (ET)	Specific (CBT)
Motivational learning		Learning motivation for therapy with articulation of initial wish for improvement and expectation of learning capabilities	Learning motivation for ET with formulation of motivational experience of mental distress or wish for self-knowledge and addressing of initial wishes for authenticity and self-exploration and expectation of learning capabilities for self and life	Learning motivation for CBT with formulation of motivational experience of mental distress or mental disorders and addressing of initial wishes for fixation of improvement of mental state and expectation of learning tools for coping with thoughts, actions and feelings
Learning about initial and previous experiences	**1. Self and life**	Learning about problematic self-image and self-relation and lack of abilities to follow values and direction in life		
	2. Thinking, acting and feeling	Learning about lack of abilities for coping with difficulties	Learning about lack of abilities for taking responsibility and making choices	Learning about problematic way of thinking and acting
	3. Relations to others	Learning about problematic way of relating with lack of abilities to engage as oneself in relations		
Learning outcomes	**1. Self and life**	Learning a caring and valuing self-relation with a changed self-image and capabilities for following values and direction in life	Learning authentic self-relation, more self-insight and insight into life with engagement, satisfaction and courage in life	Learning self-capability and self-esteem.

	2. Thinking, acting and feeling	Learning changed way of acting and thinking and capabilities for making choices, taking responsibility and coping with difficulties.	Learning an open and positioning way of approaching living	Learning an organized and appropriate way of approaching living
	3. Relations to others	Learning to engage as oneself in mutual relationships with abilities to accept others and set limits in relationships		Learning capabilities to choose one's relationships and separate oneself from others
Design for facilitation of learning		1. Exploring perspectives for altering subjective comprehension and attitude	1. Demanding transformation of self and life	1. Focusing on positive self-awareness
		2. Questioning experiences	2. Client-following, directional and in-depth exploration	2. Learning of tools
				3. Specific techniques for learning
Therapist	**Educational role**	Educational role for facilitation of learning	Companion and revelator	Guide, teacher or partner
	Educational qualities	Educational qualities for facilitation of learning	Aware, knowing or engaging	Guiding, teaching or partnering
	Relational qualities	Relational qualities for facilitation of learning	Supporting, assisting and giving recognition	Empathy and friendliness
Therapeutic relationship		Strong learning relationship	Non-judgmental and mutual meeting	Exchange